

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 4 8 9

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|  |   |   |  |  |   |
|--|---|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>JULIA C ADAMS</b>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4/11/82</b>                              |  | 2b. HOUR<br>MIN.<br><b>115P</b>   |
| 3. SEX<br><b>FEMALE</b>  | 4. RACE<br><b>WHITE</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4 13 90</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS.<br><b>91</b>                                 | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County MD.</b>                  |   |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Joseph Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>AT HOME</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY   |
| 13a. STATE<br><b>MARYLAND</b>  |   |   | 13b. COUNTY<br><b>BALTO.</b>   | 13c. CITY OR TOWN<br><b>3091 TEXAS AVE.</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                               |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>CHARLES ROBINSON</b>  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>HULDAH HAZLETT</b>             |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>212-09-7732</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>FAMILY RECORDS</b>                                    |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiovascular failure</b><br><b>4292</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Severe recent CVA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>ASCVD</b>                                     |   |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |   |   |  |  |   |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (this hospital) attended the deceased from <b>4/6</b> 19 <b>82</b> , to <b>4/11</b> 19 <b>82</b> , that (we) last<br>saw the deceased alive on <b>4/11</b> 19 <b>82</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated<br>above, (we) (did) (view) the body after death. |   |   |  |  |   |
| 22b. SIGNATURE<br><b>G D Harvey</b>  |   | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>4/11/82</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>GREGORY HARVEY</b>   |   | 22e. ADDRESS<br><b>ST. JOSEPH'S HOSP</b>  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |   | 23b. DATE<br><b>4/14/82</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BEAUFORT MEMORIAL</b>                     |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>HARFORD COUNTY MD.</b>   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>EVANS FUNERAL Chapel</b>  |   | ADDRESS<br><b>8800 Harford Rd.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 14 1982</b>                                  |   |
|  |   |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>James J. Nathan</b>                                 |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the hospital or attending physician.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 2 0 8 4 9 0  
CERTIFICATE OF DEATH

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |                         |   |  |   |  |
|--|-------------------------|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>VALLIE L. AIREY</b>  |                         |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>04 10 82</b> |   | 2b. HOUR<br><b>P.M.</b>                                      |
| 3. SEX<br><b>FEMALE</b>  | 4. RACE<br><b>WHITE</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>06 15 03</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>78 YRS</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>NORTH CAROLINA</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY MD.</b>                             |  |
| 10. CITY OR TOWN OF DEATH<br><b>UPLANDS</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>4361 OLD FREDERICK ROAD</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HAIR DRESSER</b>         |  |
| 13a. STATE<br><b>MARYLAND</b>  |                         | 13b. COUNTY<br><b>BALTIMORE</b>   | 13c. CITY OR TOWN<br><b>UPLANDS</b>                    | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>GRANT SEXTON</b>  |                         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>EMMA LOFLIN</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |                         | 16b. SOCIAL SECURITY NO.<br><b>216-09-0830</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>IRIS HOFMANN 733 CHARING CROSS ROAD, 21229</b>                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic breast cancer</b><br><b>1749</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |                         |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 yrs</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |                         |   |  |   |  |
| 19a. DATE OF OPERATION   |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |                         | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7/81</b> to <b>7/82</b> , 19____, that (I) (we) last saw the deceased alive on <b>3</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.  |                         |   |  |   |  |
| 22b. SIGNATURE<br>  |                         |   |  | 22c. DATE SIGNED<br><b>4/11/82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Richard Ambinder</b>   |                         |   |  | 22e. ADDRESS<br><b>JOHNS HOPKINS HOSPITAL, ONCOLOGY DEPT.</b>                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |                         | 23b. DATE<br><b>04-14-82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>LOUDON PARK</b>  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE CITY MARYLAND</b>   |                         | 23e. DATE REC'D. BY REGISTRAR<br><b>APR 12 1982</b>   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE. 21229</b>  |                         | 25a. REGISTRAR'S SIGNATURE<br>                         |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 4 9 1

REG. NO.

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME AKA FIRST LILLIAN MIDDLE L. LAST ALBAN ALBAN<br>(TYPE OR PRINT) LILLIAN A. ALBAN   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>4 13 82   |  | 2b. HOUR<br>11:32 P.M.  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>12 16 20   |  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.<br>61 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>CATONSVILLE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1305 Hilton Terrace |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>INSPECTOR  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>KOPPERS CORP.  |  |
| 13a. STATE<br>MARYLAND  |  | 13b. COUNTY<br>BALTIMORE  |  | 13c. CITY OR TOWN<br>CATONSVILLE  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>RAYMOND  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>AGNES DERECKI   |  | 13e. STREET ADDRESS<br>1305 HILTON TERRACE, 21228   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>232-26-1341   |  | 17. INFORMANT ADDRESS<br>VERNON ALBAN 1305 HILTON TERRACE, 21228  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) METASTATIC CANCER<br>1629 } DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) LUNG CANCER<br>(c) |  |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: n/a  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION<br>n/a   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>n/a   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br>n/a   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>n/a 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)<br>n/a   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/><br>n/a  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>n/a  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE<br>n/a   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from JULY 1 19 80 to APRIL 14 19 82, that (I) (we) last saw the deceased alive on MARCH 31 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.  |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br>Randy X. Reese, MD  |  |   |  | DEGREE<br>M.D.  |  | 22c. DATE SIGNED<br>4/14/82   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Randy Reese, M.D.  |  |   |  | 22e. ADDRESS<br>3459 St. John's Lane  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>ENTOMBMENT   |  | 23b. DATE<br>04-17-82   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>LOUDON PK. MAUSOLEUM  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>BALTIMORE CITY MARYLAND  |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS<br>HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE. 21229   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>APR 16 1982  |  |   |  |
|   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br>Charles J. [Signature]  |  |   |  |

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APR 10 1985  
J. L. Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 4 9 2

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |  |  |   |   |                           |  |
|---|--|--|---|---|---------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>DAVID PRESLEY ALEXANDER</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4 09 82</b> |   | 2b. HOUR<br><b>6:35AM</b> |  |
| 3. SEX<br><b>M</b>  |  | 4. RACE<br><b>B</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 14 27</b>   |                           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Winston-Salem NC</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                           |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON, MD.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>GBMC-6701 N. CHARLES ST.</b> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY MD.</b>   |                           |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |   |   |                           |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                           |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>David Alexander</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lucille Prestley</b>   |   | 13e. STREET ADDRESS<br><b>2231 E. North Ave.</b>  |                           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>240-34-3246</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>Lorraine Alexander 2231 E. North Ave.</b>  |                           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>1539 IMMEDIATE CAUSE (a) CARDIOPULMONARY FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>PULMONARY EDEMA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>METASTATIC COLONIC CARCINOMA</b>          |  |  |   |   |                           |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |  |  |   |   |                           |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                           |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |                           |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>4-3 82 4-9 82</b>   |                           |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4-9 82</b> to <b>4-9 82</b> , that (I) (we) last saw the deceased alive on <b>4-9 82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |   |                           |  |
| 22b. SIGNATURE<br><b>Edward P. Grace MD</b>   |  | DEGREE<br><b>MD</b>  |   | 22c. DATE SIGNED<br><b>4/09/82</b>  |                           |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>EDWARD P. GRACE, MD.</b>  |  | 22e. ADDRESS<br><b>12 SUNNY MEADOW CT. 21209</b>   |   |   |                           |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>4/14/82</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Maryland Veterans Cem</b>  |                           |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H, Inc.</b>   |  | ADDRESS<br><b>1101 E. North Ave.</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 12 1982</b>   |                           |  |
|   |  |  |   | 25b. REGISTRAR'S SIGNATURE<br><b>James J. North</b>   |                           |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Crownsville MD</b>   |  |  |   |   |                           |  |

THE, NO. 100-20111, CHARLES ST.

WASHERMAN, ARY BAILLE

PLANTARY BERRY

REPLANTIC L. 100-20111

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1. STATE  
REGISTRAR

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 4 9 3

REG. NO.

|  |  |   |   |   |  |   |  |
|--|--|---|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>William Robert Anderson</b> |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4 11 82</b> |   |  | 2b. HOUR<br>M<br><b></b>  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 31 1902</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                               |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                             |  |
| 10. CITY OR TOWN OF DEATH<br><b>Eastwood</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>8054 Gough Street</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Steel Worker</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Beth. Steel</b>   |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>   |   | 13c. CITY OR TOWN<br><b>Eastwood</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William G. Anderson</b>                       |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Millie Condron</b>  |   | 13e. STREET ADDRESS<br><b>8054 Gough Street</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>          |  | 16b. SOCIAL SECURITY NO.<br><b>213-07-9940</b>  |   | 17. INFORMANT<br><b>Alice R. Anderson</b>   |  | ADDRESS<br><b>8054 Gough Street Balto., MD. 21224</b>   |  |

|  |  |  |  |
|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cancer of the lung</b><br><b>1629</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Pulmonary edema</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>12 months</b><br><b>1 day</b> |  |
|--|--|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 19a. DATE OF OPERATION<br><b>4-11-82</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b></b>                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>10 4-11 1982</b>            |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b></b> |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b></b> |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b></b>                              |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4-9-82</b> to <b>4-11-82</b> , that (I) (we) last saw the deceased alive on <b>4-9-82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>John Conway</b>   |  |   |  | DEGREE<br><b></b>   |  | 22c. DATE SIGNED<br><b>4/12/82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. John Conway</b>  |  |   |  | 22e. ADDRESS<br><b>3401 Dundalk Ave</b>   |  |   |  |

|  |  |                               |  |   |  |  |  |
|--|--|-------------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>4/14/1982</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn</b>       |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore MD.</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Duda-Ruck, Inc. 7922 Wise Avenue Dundalk, MD. 21222</b> |  |                               |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 14 1982</b>         |  |  |  |
|  |  |                               |  | 25b. REGISTRAR'S SIGNATURE<br><b>Frances J. [Signature]</b> |  |  |  |

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APR 14 1985

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 4 9 4

REG. NO.

|  |  |   |   |  |  |
|--|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>IDA ANSHEL  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>APRIL 8, 1982   |  | 2b. HOUR A.<br>12:15 M.  |
| 3. SEX<br>FEMALE   | 4. RACE<br>WHITE   | 5. DATE OF BIRTH MONTH DAY YEAR<br>APR. 1, 1894   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>88 YRS.   | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>RUSSIA  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.                         |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>JEWISH CONVALESCENT CENTER |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>MIDWIFE                          | 12b. KIND OF BUSINESS OR INDUSTRY<br>BIRTHING  |  |
| 13a. STATE<br>MARYLAND   |  |   | 13b. COUNTY<br>BALTO.   | 13c. CITY OR TOWN<br>OWINGS MILLS  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                               |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>UNKNOWN PEARLMAN  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>UNKNOWN   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>216-16-6984   | 17. INFORMANT ADDRESS<br>HEBREW BURIAL & SOCIAL SERVICE<br>1330 REISTERSTOWN RD. BALTO., MD 21208 |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac arrest</u><br><u>4140</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart Disease</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____ |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>1 day</u><br><u>3 years</u>   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Organic Brain Disease</u>  |  |   |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                       |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 4</u> , 19 <u>79</u> , to <u>april 9</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>april 7</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.                      |  |   |   |  |  |
| 22b. SIGNATURE<br><u>Manuel Levin</u>  |  | DEGREE <u>MD</u>  |   | 22c. DATE SIGNED<br><u>4/9/82</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MANUEL LEVIN, M.D.  |  | 22e. ADDRESS<br>6101 PARK HTS. AVE. BALTO., MD 21215  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  | 23b. DATE<br>APR. 12, 1982  | 23c. NAME OF CEMETERY OR CREMATORY<br>MIKRO KODESH-BETH ISRAEL                                    |  | 23d. LOCATION CITY OR TOWN COUNTY<br>BALTIMORE MARYLAND  |
| 24. FUNERAL DIRECTOR NAME<br>SOL LEVINSON & BROS., INC.  |  | 25a. DATE RECD BY REG. MAR. 15, 1982  |   | 25b. DATE RECD BY REG. MAR. 15, 1982   |  |
| 6010 REISTERSTOWN RD. BALTO., MD 21215   |  |   |   |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

U.S. 100

100

100

100

100

100

100

APR 18 1985



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of death.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 4 9 5

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|   |   |   |  |  |   |  |                                   |  |
|---|---|---|--|--|---|--|-----------------------------------|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)  |   |   | 2a. DATE OF DEATH  |  |   | 2b. HOUR   |                                   |  |
| Clarence R. ANTHONY, Sr.  |   |   | April 11, 1982   |  |   | 8:02AM   |                                   |  |
| 3 SEX   | 4 RACE  | 5. DATE OF BIRTH  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  |   | 7. IF UNDER 1 YEAR   |                                   |  |
| Male  | White   | Jan. 20, 1899   | 83   |  |   | MONTHS DAYS HOURS MIN.   |                                   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9 BALTIMORE CITY OR COUNTY OF DEATH   |  |                                   |  |
| Maryland  | U.S.A.  |   |  |  | Baltimore County MD.  |  |                                   |  |
| 10 CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |   |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| Rossville   | Franklin Square Hospital  |   |  | Manager  |   |  | Warehouse                         |  |
| 13a. STATE  |   |   | 13b. COUNTY  | 13c. CITY OR TOWN  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS               |  |
| Maryland  |   |   | Baltimore  | Dundalk  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |  | 3432 Wallford <del>Rm</del> Drive |  |
| 14 FATHER'S NAME  |   |   | 15 MOTHER'S MAIDEN NAME  |  |   |  |                                   |  |
| Harmon K. Anthony   |   |   | Mammie Burnett   |  |   |  |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |   |   | 16b. SOCIAL SECURITY NO.   |  | 17 INFORMANT ADDRESS  |  |                                   |  |
| No  |   |   | 215-03-5858  |  | Clarence R. Anthony, Jr. 165 Bennett Rd.                                      |  |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u><br><u>4860</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <u>Septic Shock</u><br>(c) <u>Pneumonia</u>  |   |   |  |  |   |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u>  |   |   |  |  |   |  |                                   |  |
| 19a. DATE OF OPERATION  |   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |   | 20a. AUTOPSY?  |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|   |   |   |  |  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |                                   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK  |   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |                                   |  |
| 22a. I certify that <u>X</u> (this hospital) attended the deceased from <u>April 9,</u> 19 <u>82</u> , to <u>April 11,</u> 19 <u>82</u> , that <u>X</u> (we) last saw the deceased alive on <u>April 11,</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <u>XX</u> (we) (did) (do) <u>XX</u> view the body after death. |   |   |  |  |   |  |                                   |  |
| 22b. SIGNATURE<br><u>Stephen Francis Waters</u>   |   |   |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                   | 22c. DATE SIGNED<br><u>4-11-82</u>                             |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Stephen Francis Waters M.D.</u>   |   |   |  |  | 22e. ADDRESS<br><u>9000 Franklin Square Dr., 21237</u>                        |  |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |   |   | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>COUNTY STATE     |  |
| Burial  |   |   | Apr. 14, 1982  |  | Parkwood  |  | Baltimore Maryland                |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><u>Leonard J. Ruck, Inc. Baltimore, Maryland</u>  |   |   |  |  |   | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><u>APR 12 1982</u> <u>[Signature]</u>  |                                   |  |

080805-5

RECEIVED  
JAN 10 1965  
U.S. AIR FORCE  
HONOLULU, HAWAII

TO: SAC, HONOLULU (100-100000)  
FROM: SAC, SAN FRANCISCO (100-100000)  
SUBJECT: [Illegible]

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 4 9 6

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |                                    |  |   |  |                          |                                   |               |  |                    |  |
|--|--|---|--|---|------------------------------------|--|---|--|--------------------------|-----------------------------------|---------------|--|--------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |   | FIRST  | MIDDLE  | LAST                               | 2a. DATE OF DEATH  |   |  |                          | MONTH                             | DAY           | YEAR   | 2b. HOUR           |  |
| Herbert Aaron ANTIN  |  |   |  |   |                                    | April 30, 1982   |   |  |                          |                                   |               |  | 12:27 <sup>a</sup> |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH  |                                    | 6. AGE   |   | 7. YRS.  |                          | IF UNDER 1 YEAR                   |               | IF UNDER 24 HRS.                             |                    |  |
| MALE   |  | WHITE   |  | MAY 25, 1916  |                                    | 65   |   |  |                          | MONTHS                            |               | DAYS   |                    |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    | 9. BALTIMORE CITY OR COUNTY OF DEATH   |   |  |                          |                                   |               |  |                    |  |
| NEW YORK   |  | USA   |  |   |                                    | Baltimore County   |   |  |                          | MD.                               |               |  |                    |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |                                    | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |   |  |                          | 12b. KIND OF BUSINESS OR INDUSTRY |               |  |                    |  |
| BALTIMORE  |  | FRANKLIN SQUARE HOSPITAL  |  |   |                                    | VENDING  |   |  |                          | RETAIL                            |               |  |                    |  |
| 13a. STATE   |  |   | 13b. COUNTY  |   | 13c. CITY OR TOWN                  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS      |                                   | 13f. ZIP CODE |  |                    |  |
| MARYLAND   |  |   | BALTO.   |   | ESSEX                              |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 33A2 BEECH DR.           |                                   | #21220        |  |                    |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST                          |   |                                    | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES OR UNKNOWN)  |   |  | 16b. SOCIAL SECURITY NO. |                                   |               | 17. INFORMANT                                |                    |  |
| LEWIS  |  |   | ANTIN  |   |                                    | SADIE  |   |  | YES                      |                                   |               | MRS. MARGARET ANTIN                          |                    |  |
|  |  |   |  |   |                                    |  |   |  | WWII-NAVY                |                                   |               | 33A2 BEECH DR. ESSEX, MD 21220               |                    |  |
|  |  |   |  |   |                                    |  |   |  | 083-10-5918              |                                   |               |  |                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br>4249<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) <b>Cardiac Arrhythmia</b><br>(c) <b>Valvular Heart Disease</b>   |  |   |  |   |                                    |  |   |  |                          |                                   |               | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1  |  |   |  |   |                                    |  |   |  |                          |                                   |               |  |                    |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |                                    | 20a. AUTOPSY?  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                          |                                   |               |  |                    |  |
|  |  |   |  |   |                                    | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                          |                                   |               |  |                    |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |                          |                                   |               |  |                    |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |                                    | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |                          |                                   |               |  |                    |  |
|  |  |   |  |   |                                    |  |   |  |                          |                                   |               |  |                    |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 30, 19 82, to April 30, 19 82, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 30, 19 82, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (do not) know the body after death. |  |   |  |   |                                    |  |   |  |                          |                                   |               |  |                    |  |
| 22b. SIGNATURE   |  |   | DEGREE   |   |                                    | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |  | 22c. DATE SIGNED         |                                   |               |  |                    |  |
| Michael Heller   |  |   |  |   |                                    |  |   |  | 4/30/82                  |                                   |               |  |                    |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |   | 22e. ADDRESS   |   |                                    |  |   |  |                          |                                   |               |  |                    |  |
| Michael Heller M.D.  |  |   | 9000 Franklin Square Drive 21237                                       |   |                                    |  |   |  |                          |                                   |               |  |                    |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  |   | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY |  | 23d. LOCATION   |  |                          |                                   |               |  |                    |  |
| BURIAL   |  |   | MAY 2, 1982  |   | BALTIMORE HEBREW                   |  | BALTIMORE COUNTY MARYLAND   |  |                          |                                   |               |  |                    |  |
| 24. FUNERAL DIRECTOR   |  |   | 25a. DATE REC'D. BY REGISTRAR  |   |                                    | 25b. REGISTRAR'S SIGNATURE   |   |  |                          |                                   |               |  |                    |  |
| SOL LEVINSON & BROS., INC.<br>6010 REISTERSTOWN RD. BALTO., MD 21215   |  |   | MAY 4 1982   |   |                                    | [Signature]  |   |  |                          |                                   |               |  |                    |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS ENCOUNTERED, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                         |  |  |  |   |  |   |  | REG. NO. 08497   |  |
|--|--|-------------------------|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>LILIAN M ARMETTA</b>  |  |                         |  |  |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input type="checkbox"/> MONTH DAY YEAR <b>APRIL 30 1982</b> |  | 2b. HOUR <b>6:15</b>  |  | 2c. DATE OF DEATH<br>MONTH DAY YEAR <b>APR 30 1982</b>                   |  |
| 3. SEX <b>FEMALE</b>   |  | 4. RACE <b>WHITE</b>    |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>FEB 17 1913</b>  |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY YRS. <b>69</b>   |  | IF UNDER 1 YR. MONTHS DAYS  |  | IF UNDER 24 HRS. HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MASS.</b>   |  |                         |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CO MD.</b>             |  |
| 10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>   |  |                         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>4119 GLEN PARK DRIVE</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>KIRKS SILVER</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>SALES</b>                           |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |                         |  |  |  |   |  |   |  |  |  |
| 13a. STATE <b>MD</b>   |  | 13b. COUNTY <b>BALT</b> |  | 13c. CITY OR TOWN <b>BALT</b>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>      |  | 13e. STREET ADDRESS <b>4119 GLEN PARK RD BALT 21236</b>   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>GUSTAV DAHLSTROM</b>   |  |                         |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>IDA OLSEN</b>                                    |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>NO</b>  |  |                         |  | 16b. SOCIAL SECURITY NO. <b>219 60 8885</b>  |  | 17. INFORMANT ADDRESS <b>FAMILY RECORDS</b>   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>(c) _____  |  |                         |  |  |  |   |  |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. _____   |  |                         |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                     |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                         |  |  |  |   |  |   |  |  |  |
| ACTUAL SIGNATURE <b>Paul F Guerin</b>  |  |                         |  | TITLE (SPECIFY) <b>DEPUTY</b>  |  |   |  | DATE SIGNED <b>4/30/82</b>  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>PAUL F GUERIN</b>   |  |                         |  | ADDRESS <b>1311 WESTERN RUN RD CUCKEYVILLE MD 21030</b>  |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>  |  |                         |  | 23b. DATE <b>5-3-1982</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>LORRAINE PARK</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE <b>BALTIMORE MARYLAND</b>  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS <b>EVANS FUNERAL CHAPEL 8800 HARFORD ROAD</b>   |  |                         |  |  |  | 25a. DATE REC'D. BY REGISTRAR. <b>MAY 5 1982</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>Frances Santantonio</b>   |  |  |  |

1930

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 2 0 8 4 9 8  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |  |  |   |  |  |  |
|---|--|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Nancy R. Auffarth  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>4 8 1982  |  |   |  | 2b. HOUR<br>M  |  |
| 3 SEX<br>Female   |  | 4 RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>2 3 1918   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>64 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                     |  |  |  |
| 10 CITY OR TOWN OF DEATH<br>Dundalk   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>7629 South Bend Road |  |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife                    |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a STATE<br>Maryland   |  | 13b COUNTY<br>Baltimore   |  | 13c CITY OR TOWN<br>Dundalk  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e STREET ADDRESS<br>7629 South Bend Road                               |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Vincent Mazza  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Rosa Papa   |  |   |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  |   |  | 16b SOCIAL SECURITY NO.<br>217-07-5246   |  | 17. INFORMANT<br>George J. Auffarth   |  |  |  |
|   |  |   |  | ADDRESS 7629 S. Bend Road<br>Baltimore, MD 21222   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>metastatic Ovarian Carcinoma</u><br>1830<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                             |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____   |  |   |  |  |  |   |  |  |  |
| 19a DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |  |  |   |  |  |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                   |  |  |  |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 19 82</u> to <u>April 19 82</u> that (I) (we) lost<br>saw the deceased alive on <u>March 19 82</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                                    |  |   |  |  |  |   |  |  |  |
| 22b SIGNATURE<br><u>Doris M. Hahn</u>   |  |   |  |  |  | DEGREE<br>MD  |  | 22c. DATE SIGNED<br>4/9/82   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Doris M. Hahn  |  |   |  |  |  | 22e ADDRESS<br>5801 Loch Raven Blvd.  |  |  |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |   |  | 23b DATE<br>4/10/82  |  | 23c NAME OF CEMETERY OR CREMATORY<br>Meadowridge Memorial                                       |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Dorsey, Howard Maryland    |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>Duda-Ruck, Inc.<br>7922 Wise Avenue, Dundalk, Maryland 21222   |  |   |  |  |  | 25a DATE REC'D. BY REGISTRAR<br>APR 14 1982   |  |  |  |

APR 14 1985  
J. J. J. J. J.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |  |                                   | 8 2 0 8 4 9 9  |  |
|---|--|---|--|---|--|---|--|--|-----------------------------------|--|--|
| 1 - FOR<br>STATE<br>REGISTRAR   |  | REG. NO.  |  |   |  |   |  |  |                                   |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST   |  | MIDDLE  |  | LAST  |  | 2a. DATE OF DEATH  |                                   | 2b. HOUR   |  |
| Evelyn M. BAILEY  |  |   |  |   |  |   |  | April 6, 1982  |                                   | 3:55P <sup>M</sup>   |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  | IF UNDER 1 YEAR  |                                   | IF UNDER 24 HRS  |  |
|   |  |   |  | MONTH DAY YEAR<br>Feb 23, 1912  |  | 70 YRS.   |  | MONTHS DAYS  |                                   | HOURS MIN.   |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County  |  |  | MD.                               |  |  |
| 10. CITY OR TOWN OF DEATH<br>XE Rossville   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Franklin Square Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife                   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Perry Hall   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>4327 Falls Park Rd  |                                   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>George Stadelman  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Bessie McComas   |  |   |  |  |                                   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>215-24-6077   |  | 17. INFORMANT<br>Mr Donald L Bailey   |  |   |  | ADDRESS<br>Same  |                                   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Pulmonary edema<br>5140<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |  |   |  |   |  |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10.  |  |   |  |   |  |   |  |  |                                   |  |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |  |                                   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |                                   |  |  |
| 22a. I certify that (this hospital) attended the deceased from March 30, 19 82, to April 6, 19 82, that (we) last saw the deceased alive on April 6, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we did) (did not) view the body after death.  |  |   |  |   |  |   |  |  |                                   |  |  |
| 22b. SIGNATURE<br>Chris Berchelmann M.D.<br>DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>  |  |   |  |   |  |   |  | 22c. DATE SIGNED<br>4/6/82   |                                   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Chris Berchelmann  |  |   |  |   |  | 22e. ADDRESS<br>9000 Franklin Square Dr., 21237   |  |  |                                   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>4/9/82   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Moreland Mem Park   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland                                |  |  |                                   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Leonard J Ruck Inc. Baltimore, Maryland   |  |   |  |   |  | 25a. RECEIVED BY REGISTER<br>APR 8 1982   |  |  |                                   |  |  |

MEDICAL CERTIFICATION

1948-1-3

RECEIVED

TO THE DIRECTOR  
OF THE BUREAU OF  
THE ARMY

RECEIVED



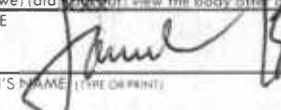
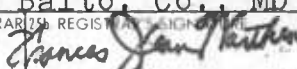
THE BUREAU OF THE ARMY

10

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 5 0 0

REG. NO.

|   |  |   |   |  |  |
|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>JOHN H BANDEL  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>4-22-82                                    |  | 2b. HOUR<br>6:05a M  |
| 3. SEX<br>Male  | 4. RACE<br>White   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>April 29, 1905  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>76 YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>TOWSON   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ST. JOSEPH HOSPITAL |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Steel Charger |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Steel   |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Baltimore  | 13c. CITY OR TOWN<br>21204  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John H. Bandel, Sr.   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Elizabeth Weber  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>217-09-7026   |   | 17. INFORMANT<br>ADDRESS<br>Nellie R. Bandel Baltimore, MD 21204   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIAC ARRHYTHMIA</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>ACUTE MYOCARDIAL INFARCTION</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____  |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (he/she) attended the deceased from <u>4-13</u> , 19 <u>82</u> , to <u>4-22</u> , 19 <u>82</u> , that (he/she) lost saw the deceased <u>4-22</u> , 19 <u>82</u> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, (he/she) did not view the body after death.              |  |   |   |  |  |
| 22b. SIGNATURE<br>   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                   |   | 22c. DATE SIGNED<br>4-22-82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>SAMUEL LEE, M.D.   |  | 22e. ADDRESS<br>7620 YORK ROAD TOWSON, MD 21204   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>Apr. 24, '82   | 23c. NAME OF CEMETERY OR CREMATORY<br>Dulaney Valley Mem. Gar. Balto. Co., MD     |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |
| 24. FUNERAL DIRECTOR<br>NAME<br>William E. Johnson  |  | ADDRESS<br>8521 Loch Raven Blvd   |   | 25a. DATE REC'D. BY REGISTRAR (b) REGISTRAR'S SIGNATURE<br>APR 23 1982  |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

0018



*[Handwritten signature or initials]*

*[Faint handwritten text at the bottom left corner]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |  |                                   | 8 2 0 8 5 0 1   |  |
|--|--|--|--|---|--|--|--|--|-----------------------------------|---|--|
| 1- FOR<br>STATE<br>REGISTRAR   |  | REG. NO.   |  |   |  |  |  |  |                                   |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Eleanor S. BARNES   |  |  |  |   |  | 2a. DATE OF DEATH<br>April 10, 1982  |  |  | 2b. HOUR<br>1:37 P.               |   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>white   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>6 6 1905  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>76 YRS.                                     |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |                                   | IF UNDER 24 HRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Balto., MD  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                   |  |  |                                   |   |  |
| 10. CITY OR TOWN OF DEATH<br>Balto.  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>FRANKLIN SQUARE HOSP. |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)               |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |   |  |
| 13a. STATE<br>MD   |  |  |  |   |  | 13b. CITY OR TOWN<br>Joppatown   |  | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                   | 13e. STREET ADDRESS<br>818 Falconer Rd 21085  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William Barnes   |  |  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Ellsie Barnes                 |  |  |                                   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>217 26 7222  |  | 17. INFORMANT<br>Carolyn Stevens  |  |  |  | ADDRESS<br>818 Falconer Rd Joppatown   |                                   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiorespiratory failure</u><br>4860<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Pneumonia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>1 day</u> |  |  |  |   |  |  |  |  |                                   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |  |  |  |   |  |  |  |  |                                   |   |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |                                   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |                                   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from<br>saw the deceased alive on <u>4/10</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above (I) (we) (did) (did not) view the body after death.    |  |  |  |   |  |  |  |  |                                   |   |  |
| 22b. SIGNATURE<br>N. Joseph Haroun   |  |  |  |   |  | DEGREE<br>MD   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                   | 22c. DATE SIGNED<br>4/13/82   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Haroun  |  |  |  |   |  | 22e. ADDRESS<br>9101 Franklin Square Dr., Balto., MD 21237                     |  |  |                                   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  | 23b. DATE<br>4-14-1982   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Moreland Mem. Pk.   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Parkville Balto MD.              |  |  |                                   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Evaas Funeral Chapel 8800 Harford Rd   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>APR 14 1982                                   |  | 25b. REGISTRAR'S SIGNATURE<br>Thomas J. Haroun   |                                   |   |  |

MEDICAL CERTIFICATION

10061

APR 14 1985

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |   |  |                                    |  |   |  |                              | REG. NO. 8 2 0 8 5 0 2                       |  |
|---|--|--|---|--|------------------------------------|--|---|--|------------------------------|--|--|
| 1. FOR STATE REGISTRAR  |  |  | 1. DECEASED NAME (TYPE OR PRINT)                                    |  |                                    |  | 2a. DATE OF DEATH   |  | 2b. HOUR                     |  |  |
|   |  |  | MARGARET ANN BARNHART   |  |                                    |  | 4 26 82   |  | 1840 M                       |  |  |
| 3. SEX  |  | 4. RACE  |   | 5. DATE OF BIRTH   |                                    | 6. AGE (IN YEARS LAST BIRTHDAY)  |   | IF UNDER 1 YEAR  |                              | IF UNDER 24 HRS.                             |  |
| Female  |  | White  |   | 12 9 25  |                                    | 56   |   | MONTHS DAYS  |                              | HOURS MIN.                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    | 9. BALTIMORE CITY OR COUNTY OF DEATH   |   |  |                              |  |  |
| Maryland  |  | U.S.A.   |   |  |                                    | Baltimore County MD.   |   |  |                              |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |  |                                    |  |   |  |                              |  |  |
| Randallstown  |  | Baltimore County General Hospital  |   |  |                                    |  |   |  |                              |  |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |   |  |                                    |  |   |  |                              |  |  |
| Housewife   |  |  |   |  |                                    |  |   |  |                              |  |  |
| 13a. STATE  |  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN                  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS          |  |  |
| Maryland  |  |  | Baltimore   |  | Arbutus                            |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 101 St. Charles Avenue 21227 |  |  |
| 14. FATHER'S NAME   |  |  | 15. MOTHER'S MAIDEN NAME  |  |                                    |  |   |  |                              |  |  |
| Robert J. McClure   |  |  | Katherine Kilbourne   |  |                                    |  |   |  |                              |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  | 16b. SOCIAL SECURITY NO.  |  |                                    | 17. INFORMANT  |   |  | ADDRESS                      |  |  |
| NO  |  |  | 219-18-7528   |  |                                    | Ralph E. Barnhart  |   |  | 2806 Superior Ave. 21234     |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:   |  |  |   |  |                                    |  |   |  |                              | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| 4589 IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u>  |  |  |   |  |                                    |  |   |  |                              |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>HYPOTENSION</u>   |  |  |   |  |                                    |  |   |  |                              |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last   |  |  |   |  |                                    |  |   |  |                              |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>PERIOPERATIVE SHOCK</u>   |  |  |   |  |                                    |  |   |  |                              |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>HYPONATRAEMIA AND HYPERKALEMIA, JAUNDICE</u>  |  |  |   |  |                                    |  |   |  |                              |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |                                    | 20a. AUTOPSY?  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                              |  |  |
|   |  |  |   |  |                                    | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                              |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY   |  |                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |  |                              |  |  |
|   |  |  | HOUR A.M. MONTH DAY YEAR  |  |                                    |  |   |  |                              |  |  |
| 21d. INJURY OCCURRED  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |                                    | 21f. LOCATION  |   |  | CITY OR TOWN COUNTY STATE    |  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |   |  |                                    | STREET   |   |  |                              |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |  |                                    |  |   |  |                              |  |  |
| 22b. SIGNATURE  |  |  |   |  |                                    | DEGREE   |   |  | 22c. DATE SIGNED             |  |  |
| <i>Hafeez A Syed M.D.</i>   |  |  |   |  |                                    |  |   |  | 4/26/82                      |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |   |  |                                    | 22e. ADDRESS   |   |  |                              |  |  |
| HAFAEEZ A SYED M.D.   |  |  |   |  |                                    | BALTIMORE COUNTY GEN HOSP.   |   |  |                              |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY |  |   | 23d. LOCATION  |                              |  |  |
| Cremation/Burial  |  |  | 4/29/82   |  | Loudon Park Cemetery               |  |   | Baltimore County Maryland                                      |                              |  |  |
| 24. FUNERAL DIRECTOR NAME   |  |  |   |  |                                    | 25a. DATE REG. BY REGISTRAR  |   |  | 25b. REGISTRAR'S SIGNATURE   |  |  |
| Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229  |  |  |   |  |                                    | APR 28 1982  |   |  | <i>James J. Nathan</i>       |  |  |

MEDICAL CERTIFICATION

BP

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1000 12 21 10:00 AM

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  | 8 2 0 8 5 0 3  |  |
|---|--|--|--|
| 1 - FOR STATE REGISTRAR   |  | REG. NO.   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>HELEN A. BARTH</b>   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>APRIL 14, 1982</b>   |  |
| 3. SEX<br><b>FEMALE</b>   | 4. RACE<br><b>WHITE</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>AUGUST 11, 1900</b>   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b> YRS<br>IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.<br>IF UNDER 24 HRS.             |  |
| 10. CITY OR TOWN OF DEATH<br><b>COCKEYSVILLE</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>14 REEDS COURT</b> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.  |  |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD.</b> 13b. COUNTY <b>BALTO.</b> 13c. CITY OR TOWN <b>PARKVILLE</b> 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS <b>8822 AVONDALE ROAD</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>MAID</b> <b>LORD BALTO.</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>EDWARD C. FLEMING</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>CARRIE PIASS</b>   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b> (IF YES, GIVE WAR OR DATES)  |  | 16b. SOCIAL SECURITY NO.<br><b>216 05 0759</b>   |  |
| 17. INFORMANT<br><b>FAMILY RECORDS</b>  |  | ADDRESS  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC CARDIOVASCULAR</b><br><b>4292</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>DISEASE WITH HYPERTENSION</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)  |  | 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                  |  |
| 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (his hospital) attended the deceased from <b>OCT 2, 1913</b> , to <b>APR 14, 1982</b> , that (I) (we) last saw the deceased alive on <b>FEB 27, 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.                               |  |  |  |
| 22b. SIGNATURE<br><b>FAUSTO Q. AGUIRRE, JR.</b>   |  | 22c. DATE SIGNED<br><b>4-16-82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>FAUSTO Q. AGUIRRE, JR.</b>  |  | 22e. ADDRESS<br><b>8713 HARFORD ROAD</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>4-17-1982</b>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>MORLAND MEM. PK.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>PARKVILLE BALTO. MD.</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>EVANS FUNERAL CHAPEL</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 20 1982</b>  |  |
| ADDRESS<br><b>8800 HARFORD RD.</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Francis J. Nathan</b>   |  |

00100

00100

00100

1. The first part of the document is a letter from the President of the United States to the Congress, dated January 1, 1863. It is a very important document, as it contains the President's message to Congress, and is one of the most important documents in the history of the United States.

2. The second part of the document is a letter from the Secretary of the United States to the Congress, dated January 1, 1863. It is a very important document, as it contains the Secretary's message to Congress, and is one of the most important documents in the history of the United States.

3. The third part of the document is a letter from the President of the United States to the Congress, dated January 1, 1863. It is a very important document, as it contains the President's message to Congress, and is one of the most important documents in the history of the United States.

4. The fourth part of the document is a letter from the Secretary of the United States to the Congress, dated January 1, 1863. It is a very important document, as it contains the Secretary's message to Congress, and is one of the most important documents in the history of the United States.

100% Cotton Lined

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 5 0 4  
REG. NO.

|   |  |   |  |  |   |
|---|--|---|--|--|---|
| 1. FOR STATE REGISTRAR  |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  | 2b. HOUR   |   |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST  |  | APR. 14, 1982   |  | 2 P M  |   |
| 3. SEX M  |  | 4. RACE W   |  | 5. DATE OF BIRTH MONTH DAY YEAR  |   |
| APR. 14, 1982   |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS                                      |  | 7. BALTIMORE CITY OR COUNTY OF DEATH   |   |
| 68  |  | BALTO. COUNTY MD  |  | 8. MARIED <input checked="" type="checkbox"/> NEVER MARIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD  |  | 9b. CITIZEN OF WHAT COUNTRY? USA  |  | 10. CITY OR TOWN OF DEATH ESSEX  |   |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 745 MIDDLESEX RD   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) STEEL                   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |   |
| 13a. STATE MD   |  | 13b. COUNTY BALTO   |  | 13c. CITY OR TOWN ESSEX  |   |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  |  | 16. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| GEO. J. BARTON SR   |  | NELLIE MATHANET   |  | 17. STREET ADDRESS 745 MIDDLESEX RD  |   |
| 18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) UNK   |  | 18b. SOCIAL SECURITY NO. 213071468  |  | 19. INFORMANT ADDRESS DORIS BARTON ABOVE   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of colon; metastatic  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months |
| 1534 DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of colon - metastatic to liver  |  |   |  |  |   |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |   |  |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Blockage of small vessels - Trauma   |  |   |  |  |   |
| 19a. DATE OF OPERATION 7-13-81  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of colon - spread to liver |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                                  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (1) this hospital attended the deceased from 6-28-81 to 4-17-82, that (2) the deceased was alive on 2-30-82 and that (3) my (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death. |  |   |  |  |   |
| 22b. SIGNATURE J. S. Ndalen   |  | DEGREE MD   |  | 22c. DATE SIGNED 4-17-82   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. S. Ndalen  |  | 22e. ADDRESS 1012 W. 11th St. Baltimore, Md.  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL  |  | 23b. DATE 4/17/82   |  | 23c. NAME OF CEMETERY OR CREMATORY GARDENS OF FAITH  |   |
| 23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD   |  | 24. FUNERAL DIRECTOR NAME J. G. CONNELLY SONS   |  | 25. DATE REC'D. BY REGISTRAR APR 21 1982   |   |
| 25a. ADDRESS 300 MACE   |  | 25b. REGISTRAR'S SIGNATURE James J. Mathanet  |  |  |   |

100 00 20

RECEIVED  
FEB 10 1964  
U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C. 20250

TO: Mr. J. B. Jones, Jr., Director, Bureau of Plant Industry, U.S. Department of Agriculture, Washington, D.C. 20250

FROM: Mr. J. B. Jones, Jr., Director, Bureau of Plant Industry, U.S. Department of Agriculture, Washington, D.C. 20250

RE: [illegible]

[illegible]

DATE: [illegible]

SUBJECT: [illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME(5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

8 2 0 8 5 0 5

1- FOR  
STATE  
REGISTRAR

|   |         |                  |  |                |                  |   |  |       |                                      |          |          |
|---|---------|------------------|--|----------------|------------------|---|--|-------|--------------------------------------|----------|----------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                   |         |                  | FIRST  | MIDDLE         | LAST             | 2a. DATE KNOWN<br>OF DEATH  |  | MONTH | DAY                                  | YEAR     | 2b. HOUR |
| JAMES L. BARTON   |         |                  |  |                |                  | XX 4-7-82   |  |       |                                      | 19       | M        |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS)  | IF UNDER 1 YR. | IF UNDER 24 HRS. | 2c. DATE PRONOUNCED<br>DEAD   |  | MONTH | DAY                                  | YEAR     | 2d. HOUR |
| male  | white   | June 29, 1950    | 31 YRS.  |                |                  | 4-7-82 19   |  |       |                                      | 11:20 PM |          |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                             |         |                  | 7b. CITIZEN OF WHAT COUNTRY?   |                |                  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |       | 9. BALTIMORE CITY OR COUNTY OF DEATH |          |          |
| Balto., Md.   |         |                  | USA  |                |                  |   |  |       | Baltimore County MD.                 |          |          |
| 10. CITY OR TOWN OF DEATH   |         |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                |                  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |       | 12b. KIND OF BUSINESS OR INDUSTRY    |          |          |
| Cockeysville  |         |                  | 1-83 1/2 mile N. of Shawan Rd.   |                |                  | Lineman   |  |       | Telephone Co.                        |          |          |
| 13a. STATE  |         |                  |  |                |                  | 13b. COUNTY   |  |       |                                      |          |          |
| PA  |         |                  |  |                |                  | York  |  |       |                                      |          |          |
| 13c. CITY OR TOWN   |         |                  |  |                |                  | 13d. INSIDE CITY LIMITS?  |  |       |                                      |          |          |
| Stewartstown  |         |                  |  |                |                  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |       |                                      |          |          |
| 13e. STREET ADDRESS   |         |                  |  |                |                  | 13f. STREET ADDRESS   |  |       |                                      |          |          |
|   |         |                  |  |                |                  | Box 1499 R.D. #1  |  |       |                                      |          |          |
| 14. FATHER'S NAME   |         |                  |  |                |                  | 15. MOTHER'S MAIDEN NAME  |  |       |                                      |          |          |
| Arthur H. Barton, II  |         |                  |  |                |                  | Audrey Bell   |  |       |                                      |          |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) |         |                  |  |                |                  | 16b. SOCIAL SECURITY NO.  |  |       |                                      |          |          |
| No  |         |                  |  |                |                  | 216-56-5767   |  |       |                                      |          |          |
| 17. INFORMANT   |         |                  |  |                |                  | ADDRESS   |  |       |                                      |          |          |
| Patricia M. Barton  |         |                  |  |                |                  | R.D. #1 Box 1499 Stewartstown, PA   |  |       |                                      |          |          |

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cranio-cerebral trauma

DUE TO, OR AS A CONSEQUENCE OF

8120  
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS

UNDERLYING ☒ OR  
CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY

10:35 PM 4-7-82  
P.M.

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

driver of auto which impacted a tractor

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☒  
AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

hwy.

21f. LOCATION

1-83 1/2 mile N. of Shawan Rd. Cockeysville, Md.  
Cumberland, Md.

22a. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE

Margarita A. Korell, M.D.

TITLE (SPECIFY)

Assistant MEDICAL EXAMINER

DATE SIGNED 4--8-82

EXAMINER'S NAME (TYPE OR PRINT)

Margarita A. Korell, M.D.

ADDRESS 111 Penn Street

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

April 10, 1982

23c. NAME OF CEMETERY OR CREMATORY

West Liberty Cem.

23d. LOCATION (CITY OR TOWN)

White Hall, Balto., Md.

24. FUNERAL DIRECTOR

J. J. Hartenstein

ADDRESS New Freedom, PA

17349

25a. DATE REC'D. BY REGISTRAR

APR 14 1982

25b. REGISTRAR'S SIGNATURE

Name J. J. Hartenstein

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.FOR  
1. STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 5 0 6

REG. NO.

|   |  |  |   |   |  |   |  |  |  |
|---|--|--|---|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Herman Franklin BAUER</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 2, 1982</b> |   |  | 2b. HOUR<br><b>7:37P.M.</b>   |  |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Nov. 20, 1911</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>70</b> YRS  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD                              |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rosadale</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Square Hospital</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Food Broker</b>          |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Ret.</b>   |  |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>Balto.</b>   |   | 13c. CITY OR TOWN<br><b>Essex</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>1920 Wilson Point Road</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Carl Bauer</b>   |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Madlon Gross</b>  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>215-09-2913</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Hazel S. Bauer same</b>   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b><br><b>4275</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |   |   |  |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>Subdural Hematoma</b>  |  |  |   |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>April 2, 1982</b> to <b>April 2, 1982</b> , that <input checked="" type="checkbox"/> (we) lost<br>saw the deceased alive on <b>April 2, 1982</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated<br>above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death. |  |  |   |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Isadore A. Feldman</b> MD  |  |  |   |   |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>April 2, 1982</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Isadore A. Feldman, MD</b>  |  |  |   |   |  | 22e. ADDRESS<br><b>9000 Franklin Sq. Dr., Balto., MD 21237</b>                                  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>Apr. 6, 1982</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn</b>   |  | 23d. LOCATION<br><b>Woodlawn Balto. Md.</b>   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Leonard J. Ruck Inc. Baltimore, Maryland</b>   |  |  |   |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 7 1982</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Thomas J. Nathan</b>  |  |









TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |   |  |  |  | 8 2 0 8 5 0 8  |  |  |  |
|--|--|--|--|--|--|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO.   |  |  |  |   |  |  |  |  |  |  |  |
| 1. DECEASED NAME (Type or Print)   |  | FIRST  |  | MIDDLE   |  | LAST  |  | 2a. DATE OF DEATH  |  | MONTH DAY YEAR   |  | 2b. HOUR                                     |  |
| (Minnie) MINNIE Elizabeth BAUERSFELD   |  |  |  |  |  |   |  | 4-28-82  |  |  |  | 12:55am                                      |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  |   |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS                              |  |
| Female   |  | White  |  | MONTH DAY YEAR<br>9 13 02  |  |   |  | 79 YRS.  |  | MONTHS DAYS  |  | HOURS MIN.                                   |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |  |  |  |  |
| Baltimore, Md.   |  | U.S.A.   |  |  |  |   |  | BALTIMORE COUNTY MD.   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |  |  |
| TOWSON   |  | ST JOSEPH HOSPITAL   |  |  |  | Retired   |  |  |  | Restaurant   |  |  |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS  |  |  |  |  |  |
| Maryland   |  | -----  |  | Baltimore  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 3314 Foster Avenue 21224   |  |  |  |  |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |   |  |  |  |  |  |  |  |
| FIRST MIDDLE LAST  |  | FIRST MIDDLE LAST  |  |  |  |   |  |  |  |  |  |  |  |
| Henry J. Mueller   |  | Barbara Adelaide Becker  |  |  |  |   |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS  |  |   |  |  |  |  |  |  |  |
| No   |  | 213-07-98350   |  | H. William Bauersfeld Jr. 40 Dunkirk Rd.   |  |   |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 1. DEATH WAS CAUSED BY:   |  |  |  |  |  |   |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (a) 4100   |  |  |  |  |  |   |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |   |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |  |  |  |   |  |  |  |  |  |  |  |
| (b) ACUTE CORONARY OCCLUSION   |  |  |  |  |  |   |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |   |  |  |  |  |  |  |  |
| (c) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE  |  |  |  |  |  |   |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |   |  |  |  |  |  |  |  |
| CONGESTIVE HEART FAILURE   |  |  |  |  |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |  |  |
|  |  |  |  |  |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |  |  |
|  |  |  |  | HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |   |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |   |  | 21f. LOCATION  |  |  |  |  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  |  |  |   |  | STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
|  |  |  |  |  |  |   |  | 4-26 82 4-28 82  |  |  |  |  |  |
| 22a. I certify that (s) (this hospital) attended the deceased from 4-26 19 82, to 4-28 19 82, and that in (x) (our) opinion death occurred on the date and hour and from the causes stated above, (he) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE   |  |  |  | DEGREE   |  |   |  | 22c. DATE SIGNED   |  |  |  |  |  |
| AGATON H. ESCALANTE, M.D.  |  |  |  | M.D.   |  |   |  | 4/28/82  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  | 22e. ADDRESS   |  |   |  |  |  |  |  |  |  |
| AGATON H. ESCALANTE, M.D.  |  |  |  | 7620 YORK ROAD TOWSON MD 21204   |  |   |  | C/O St Joseph Hospital   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY                                  |  | 23d. LOCATION  |  |  |  |  |  |
| Burial   |  |  |  | 5-1-82   |  | Sacred Heart Cem.   |  | Dundalk Balto. Co. Md.   |  |  |  |  |  |
| 24. FUNERAL DIRECTOR   |  |  |  | 25a. DATE REC'D. BY REGISTRAR  |  |   |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |  |  |
| NAME ADDRESS   |  |  |  | APR 30 1982  |  |   |  | [Signature]  |  |  |  |  |  |
| C.S. Zeiler & Son Inc. 901 S. Conkling Street  |  |  |  |  |  |   |  |  |  |  |  |  |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGES 4 AND 5 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 6 FOR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 17 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                  |  |  |  |  |  |  |          | REG. NO. 08509   |                                   |  |  |
|---|--|------------------|--|--|--|--|--|--|----------|--|-----------------------------------|--|--|
| 1. FOR STATE REGISTRAR  |  |                  |  |  |  |  |  |  |          |  |                                   |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>JOHN J BAYER</b>  |  |                  |  |  |  | 2a. DATE KNOWN OF DEATH <input type="checkbox"/> MONTH <input checked="" type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> HOUR |  |  | 2b. HOUR |  |                                   |  |  |
| 3. SEX <b>M</b>   |  | 4. RACE <b>W</b> |  | 5. DATE OF BIRTH MONTH <b>4</b> DAY <b>12</b> YEAR <b>29</b>   |  | 6. AGE (IN YEARS) (LAST BIRTHDAY) <b>53</b> YRS.   |  | IF UNDER 1 YR. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>   |          | IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN <input type="checkbox"/> |                                   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>   |  |                  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |          | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CO</b> MD                  |                                   |  |  |
| 10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>  |  |                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>FRANKLIN SQUARE</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>WELDER</b>  |          |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |
| 13a. STATE <b>MD</b>  |  |                  |  | 13b. COUNTY <b>BALTCITY</b>  |  | 13c. CITY OR TOWN <b>BALT</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |          | 13e. STREET ADDRESS <b>4611 WHITE AVE</b> <b>BALT 21206</b>                  |                                   |  |  |
| 14. FATHER'S NAME FIRST <b>GEORGE</b> MIDDLE <b>BAYER</b> LAST <b>BAYER</b>   |  |                  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST <b>FRANCES</b> MIDDLE <b>HAAG</b> LAST <b>HAAG</b>  |  |  |          |  |                                   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>YES</b>   |  |                  |  | 16b. SOCIAL SECURITY NO. <b>220-20-8075</b>  |  | 17. INFORMANT ADDRESS <b>MAXINE BAYER 4811 WHITE AVE 21206</b>   |  |  |          |  |                                   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>4292</b><br>IMMEDIATE CAUSE (a) <b>ARTERIO SCLEROTIC CARDIO -</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>VASCULAR DISEASE</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>(c) _____   |  |                  |  |  |  |  |  |  |          |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                     |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a.  |  |                  |  |  |  |  |  |  |          |  |                                   |  |  |
| 19a. DATE OF OPERATION  |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  |  |          |  |                                   | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>   |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |          |  |                                   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |          |  |                                   |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                  |  |  |  |  |  |  |          |  |                                   |  |  |
| ACTUAL SIGNATURE <b>Paul F. Guerin</b>  |  |                  |  |  |  | TITLE (SPECIFY) <b>DEPUTY</b> MEDICAL EXAMINER   |  |  |          | DATE SIGNED <b>4/30/82</b>   |                                   |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>PAUL F GUERIN</b>  |  |                  |  |  |  | ADDRESS <b>1311 WESTERN BLVD COCKEYVILLE MD 21030</b>  |  |  |          |  |                                   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>   |  |                  |  | 23b. DATE <b>5/3/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>HOLY REDEEMER</b>  |  |  |          | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO. MD.</b>                    |                                   |  |  |
| 24. FUNERAL DIRECTOR NAME <b>J.G. CONNELLY</b> ADDRESS <b>300 MALE RD</b>   |  |                  |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>MAY 4 1982</b>  |  |  |          | 25b. REGISTRAR'S SIGNATURE <b>James J. Nathan</b>                            |                                   |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 5 1 0

REG. NO.

|  |  |   |  |   |  |  |   |  |  |  |
|--|--|---|--|---|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>EDWARD Joseph BECK</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4-27-82</b>                            |   |  | 2b. HOUR<br>MIN.<br><b>8 35</b>  |   |  |  |  |
| 3 SEX<br><b>MALE</b>   |  | 4 RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>June 15 1915</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>66 yrs</b>  |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>YRS.</b>   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County MD.</b>  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>B. Gen. Hosp.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Foreman</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>GAS+Electric</b>   |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD.</b>  |  |   | 13b. COUNTY<br><b>Balto</b>  |   | 13c. CITY OR TOWN<br><b>Reisterstown</b>                         |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>604 Church Rd.</b>                 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Alfred E. Beck</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Elizabeth Volker</b>         |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>yes</b>  |   |  |  |  |
| 16b. SOCIAL SECURITY NO.<br><b>217-01-9728</b>   |  |   | 17. INFORMANT<br>ADDRESS<br><b>Margaret Beck 604 Church Rd. Reisterstown, MD</b> |   |  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>5559</b> IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Crohn's disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>arteriosclerotic heart disease</b> |  |   |  |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>years</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                 |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)   |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)            |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4-16-</b> 19 <b>82</b> , to <b>4-27-</b> 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>4-27-</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Soon Chul Hong</b>  |  |   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>4-27-82</b>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>SOON CHUL HONG</b>   |  |   |  |   |  | 22e. ADDRESS<br><b>Baltimore County General Hospital</b>   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |   | 23b. DATE<br><b>Apr 30 1982</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Evergreen Mem. Gtr.</b> |  |   | 23d. LOCATION<br>(CITY OR TOWN) COUNTY STATE<br><b>Finksburg Carroll MD</b>  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>H. E. Schmitt Owings Mills, MD</b>  |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 30 1982</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles J. W. ...</b>   |  |  |

0 1 2 3 4 5



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

DHMH-16 50M 1/81  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |   |  |
|--|--|---|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  | 8 2 0 8 5 1 1<br>REG. NO.   |  |   |  |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST MIDDLE LAST<br>LOUISE KOHN BECKLEY  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>APRIL 19, 1982   |  | 2b. HOUR<br>6 <sup>00</sup> P.M.  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>May 12, 1911   |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br>70   |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                 |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Pikesville  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>2914 Woodvalley Drive |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker                   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Pikesville   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>2914 Woodvalley Dr.  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Walter W. Kohn  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Alice Frank   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>214-24-6988   |  | 17. INFORMANT ADDRESS<br>Joseph D. Beckley Same   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>1490</u> <u>Stroke</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral Thrombosis of Pharynx</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>2 years</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |   |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4-3-80</u> 19 <u>82</u> , to <u>4-16</u> 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>4/16/82</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                        |  |   |  |   |  |  |  |   |  |
| 22b. SIGNATURE <u>William F. Fritz</u>   |  |   |  | DEGREE <u>M.D.</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  |  | 22c. DATE SIGNED <u>4/20/82</u>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>William F. Fritz, M.D.  |  |   |  | 22e. ADDRESS<br>2 W. University Pkwy. Baltimore, Md.  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>Apr. 21, 1982  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Druid Ridge   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Pikesville, Balto., Md.                           |  |   |  |
| 24. FUNERAL DIRECTOR NAME<br>Mitchell-Wiedefeld Home, Inc. Balto. Md.  |  |   |  | ADDRESS<br>6500 York Rd.  |  | 25a. DATE REC'D. BY REGISTRAR<br>APR 22 1982   |  | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>   |  |

MEDICAL CERTIFICATION

0000 BP

11780



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 300-3500.

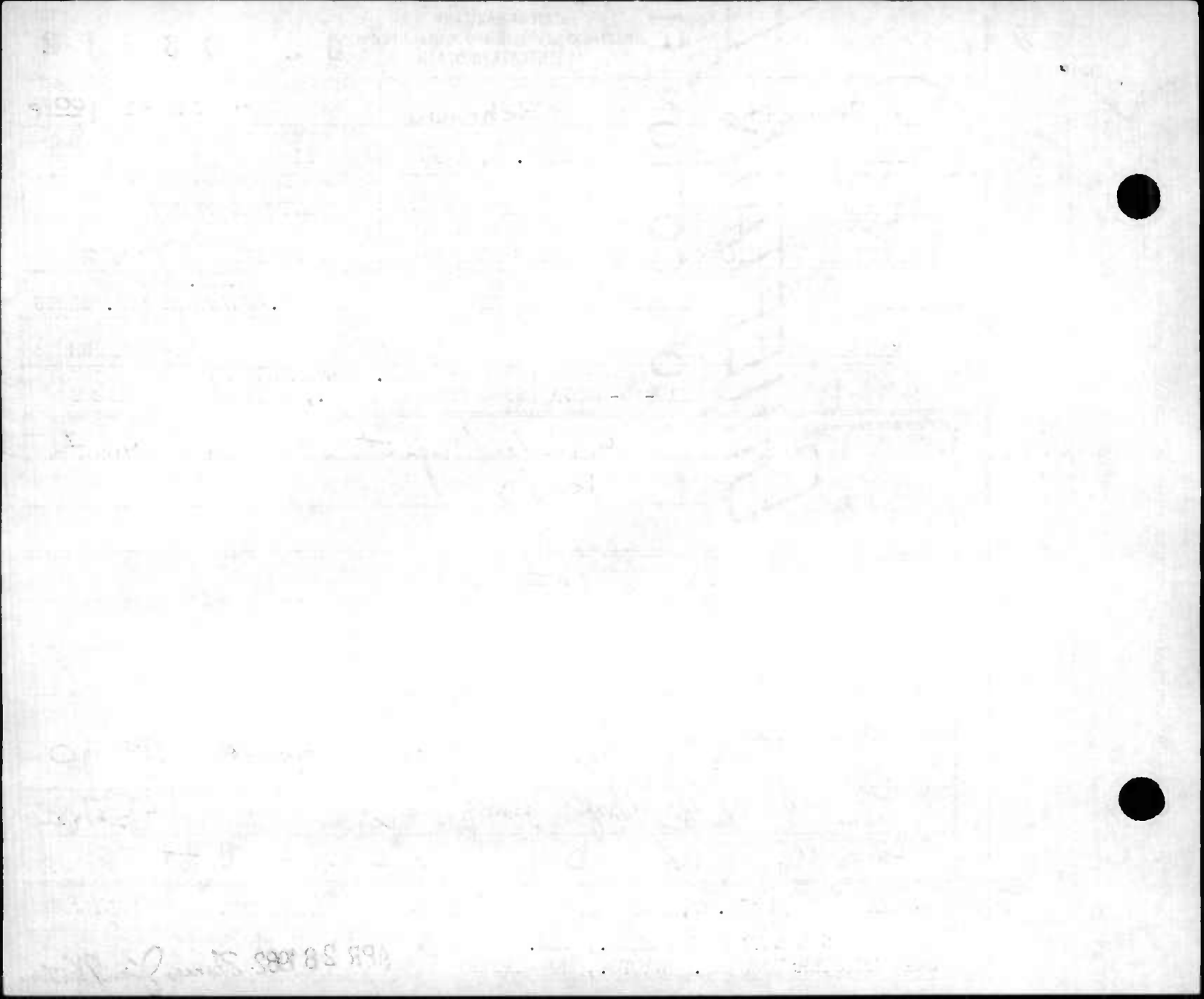
1- STATE REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 5 1 2

REG. NO.

|   |  |  |   |   |                             |  |   |   |  |                                    |  |
|---|--|--|---|---|-----------------------------|--|---|---|--|------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Jeanette Behrman</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4 26 82</b> |   | 2b. HOUR<br><b>100 P.M.</b> |  |   |   |  |                                    |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>WHITE</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>SEPT. 4, 1890</b>  |                             | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>91</b>   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |                                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                             | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY MD.</b>  |   |   |  |                                    |  |
| 10. CITY OR TOWN OF DEATH<br><b>PIKESVILLE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>MILFORD MANOR NURSING HOME</b> |   |   |                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>                                       |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>AT HOME</b>   |  |                                    |  |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>BALTIMORE</b>  |   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |                             | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |   | 13e. STREET ADDRESS<br><b>APT. 504<br/>2500 W. BELVEDERE AVE. 21215</b>   |  |                                    |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>KALMAN HORNSTEIN</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>CAROLYN UNKNOWN</b>  |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |                             |  | 16b. SOCIAL SECURITY NO.<br><b>219-36-0897A</b> |   | 17. INFORMANT<br><b>MRS. SYLVIA DEWITZ<br/>6300 RED CEDAR PL., UNIT 110 #21209</b> |                                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial infarct</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ASCVD</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Minutes</b> |  |  |   |   |                             |  |   | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Chronic CHF</b> |  |                                    |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                             | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |   |  |                                    |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |                             |  |   |   |  |                                    |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                             |  |   |   |  |                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4/25/82</b> to <b>4/26/82</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.)   |  |  |   |   |                             |  |   | 22b. SIGNATURE<br><b>Louis W. Miller M.D.</b>   |  | 22c. DATE SIGNED<br><b>4/26/82</b> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Louis W. Miller M.D.</b>  |  |  |   | 22e. ADDRESS<br><b>6804 Park Heights</b>  |                             |  |   |   |  |                                    |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>APR. 27, 1982</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>HEBREW FRIENDSHIP</b>  |                             | 23d. LOCATION<br><b>BALTIMORE COUNTY MARYLAND</b>  |   |   |  |                                    |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BROS., INC.<br/>6010 REISTERSTOWN RD. BALTO., MD 21215</b>  |  |  |   | 25a. DATE REC'D BY REGISTRAR<br><b>APR 28 1982</b>  |                             | 25b. REGISTRAR'S SIGNATURE<br><b>Thomas Jean Nathan</b>  |   |   |  |                                    |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/B1  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 5 1 3

REG. NO.

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 2a. DATE OF DEATH  |  | 2b. HOUR   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | 2a. DATE OF DEATH  |  | 2b. HOUR   |  |
| Daisie Irene BELL  |  | April 28, 1982   |  | 4:20 P.M.  |  |
| 3. SEX   | 4. RACE  | 5. DATE OF BIRTH   | 6. AGE (IN YEARS LAST BIRTHDAY)  | IF UNDER 1 YEAR  |  |
| Female   | White  | June 8, 1909   | 72   | MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |  |
| Virginia   | USA  |  | Baltimore County MD.   |  |  |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY            |
| Rossville 21237  | Franklin Sq. Hospital  |  | Machine Operator   |  | Wool Mill                                    |
| 13a. STATE   | 13b. COUNTY  | 13c. CITY OR TOWN  | 13d. INSIDE CITY LIMITS?   | 13e. STREET ADDRESS  |  |
| Maryland   | Baltimore  | Lundalk  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 1612 Four George's Ct. 21222                                   |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |
| Archie U. Shillingburg   |  | Flora Pierce   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   | 17. INFORMANT ADDRESS  |  |  |
| No   |  | 214 16 8222  | Jules Bell, Husband Same   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 1533 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last   |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) Sepsis  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma of the sigmoid colon  |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |
| Obesity  |  |  |  |  |  |
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
|  | HOUR A.M. MONTH DAY YEAR P.M. 19   |  |  |  |  |
| 21d. INJURY OCCURRED   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    | 21f. LOCATION  |  |  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (X) (this hospital) attended the deceased from April 21, 19 82, to April 28, 19 82, that (X) (we) last saw the deceased alive on April 28, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death. |  |  |  |  |  |
| 22b. SIGNATURE   |  | DEGREE   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED                             |
| Matthew Scott MD   |  |  |  |  | 4/28/82                                      |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |  |  |
| MATTHEW SCOTT MD   |  | 9000 Franklin Square Dr., 21237  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL  | 23b. DATE  | 23c. NAME OF CEMETERY OR CREMATORY   | 23d. LOCATION  |  |  |
| Burial   | May 1, 1982  | Holly Hill Memorial Gardens  | Balto. Co., Md.  |  |  |
| 24. FUNERAL DIRECTOR   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE                                     |  |
| Brazdzinski Funeral Home   |  | MAY 3 1982   |  | James J. Smith   |  |



**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO. **08514**

|  |  |                                     |  |   |  |   |  |   |  |   |  |
|--|--|-------------------------------------|--|---|--|---|--|---|--|---|--|
| 1- FOR STATE REGISTRAR   |  | 1. DECEASED NAME<br>(TYPE OR PRINT) |  | FIRST MIDDLE LAST<br><b>Anastasia Benicewicz</b>  |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED  |  | MONTH DAY YEAR<br><b>April 13 1982</b>  |  | 2b. HOUR<br><b>12:30 PM</b>   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>             |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Oct. 24 1915</b>   |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br><b>66</b> YRS.                          |  | IF UNDER 1 YR.<br>MONTHS DAYS<br><b>0 0</b>   |  | IF UNDER 24 HRS.<br>HOURS MIN.<br><b>0 0</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Baltimore, Md.</b>   |  |                                     |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Towson Baltimore County MD.</b>          |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson 21204</b>   |  |                                     |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br><b>St. Joseph's Hospital</b>                      |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>   |  | 12b. KIND OF BUSINESS<br><b>None</b>  |  |
| 13a. STATE<br><b>Md.</b>   |  |                                     |  | 13b. COUNTY<br><b>-</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br><b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>705 S. East Avenue 21224</b>                              |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joseph Dekowski</b>   |  |                                     |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Elizabeth Lewandowski</b> |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>   |  |                                     |  | 16b. SOCIAL SECURITY NO.<br><b>218 88 7488</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Michael Benicewicz, Son Balto., Md. 21220</b>  |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>9530</b> IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) <b>Cerebral Edema - from</b><br>(c) <b>Hypertension from Hanging Sudden</b>  |  |                                     |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>30 yrs</b>                       |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |                                     |  |   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |                                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                                     |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>10 P.M. 19</b>  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>  |  |                                     |  | 21e. PLACE OF INJURY (ATHOME, STREET, IN COURT, PUBLIC, ETC.)<br><b>Mental Hospital / Sheppard Pratt Hosp</b> |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>Towson Baltimore Md.</b>  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                                     |  |   |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE<br><b>Charles O'Donnell</b>   |  |                                     |  | TITLE (SPECIFY)<br><b>Deputy</b>  |  |   |  | DATE SIGNED<br><b>4/14/82</b>   |  |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Charles O'Donnell, M.D.</b>   |  |                                     |  | ADDRESS<br><b>7501 York Rd. Towson, Md. 21204</b>   |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE OR PRINT)<br><b>Burial</b>  |  |                                     |  | 23b. DATE<br><b>4/16/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Stanislaus Cemetery</b>          |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md.</b>                 |  |
| 24. FUNERAL DIRECTOR<br><b>Brzezinski Funeral Home PA 1407</b>   |  |                                     |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 16 1982</b>                           |  |   |  |   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |                                     |  |   |  |   |  |   |  |   |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

2611 BP  
DHMH-17  
(VR A15 ME (5))  
15A 2/80

APR 14 1964



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 5 1 5

REG. NO.

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST MIDDLE LAST  |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  | 2b. HOUR   |  |
| Stewart H. BENNETT  |  |  |  | April 11, 1982   |  | 3:00a M  |  |
| 1. SEX  | 4. RACE  | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR IF UNDER 24 HRS  |  |
| Male  | White  | 9 27 1912  |  | 69 YRS   |  | MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| Maryland  | U.S.A.   |  |  | Baltimore County MD.   |  | Armco  |  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  |  |  |  |
| Rossville   | Franklin Square Hospital   |  | Steel Worker   |  |  |  |  |
| 13a. STATE  | 13b. COUNTY  | 13c. CITY OR TOWN  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS  |  |  |  |
| Maryland  | Baltimore  | Dundalk  |  | 1712 Todd Avenue   |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  | ADDRESS  |  |  |  |
| John Bennett  |  | Minnia Potzer  |  | 1712 Todd Avenue Balto. MD 21222   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | ADDRESS  |  |
| No  |  | 217-09-2181  |  | Mary E. Bennett  |  | Balto. MD 21222  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atherosclerotic cardiovascular disease;</u> DUE TO, OR AS A CONSEQUENCE OF <u>myocardial infarction</u> (b) <u>Bronchopneumonia; bilateral pleural effusion</u> DUE TO, OR AS A CONSEQUENCE OF <u>Atelectasis</u> (c) <u>4100</u> Conditions, if any, which gave rise to immediate cause (a); stating the underlying cause last. |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from April 8, 19 82, to April 11, 19 82, that (we) last saw the deceased alive on April 11, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.   |  |  |  |  |  |  |  |
| 22b. SIGNATURE OF PHYSICIAN (TYPE OR PRINT)   |  |  |  | DEGREE   |  | 22c. DATE SIGNED   |  |
| Steven B. Snyder M.D.   |  |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 4/11/82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  | 22e. ADDRESS   |  |  |  |
| Steven B. Snyder, M.D.  |  |  |  | 9000 Franklin Square Drive 21237   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN   |  |
| Burial  |  | 4/14/82  |  | Gardens of Faith   |  | Baltimore, Maryland  |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS   |  |  |  | 25a. DATE REC'D. BY REG. AR. (TYPE OR PRINT)   |  |  |  |
| Duda-Ruck, Inc. 7922 Wise Avenue, Dundalk, MD 21222   |  |  |  | APR 14 1982  |  |  |  |
|   |  |  |  | 25b. SIGNATURE   |  |  |  |
|   |  |  |  | Charles D. [Signature]   |  |  |  |

*[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "The following" and "is" are faintly visible.]*

*[Handwritten signature or name, possibly "John F. ..."]*

*[Handwritten text at the bottom left corner, possibly "John F. ..."]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |                  |   |   |   |   |  |   |   | 8 2 0 8 5 1 6<br>REG. NO.   |  |                 |  |               |  |
|---|--|------------------|---|---|---|---|--|---|---|---|--|-----------------|--|---------------|--|
| 1. FOR STATE REGISTRAR<br>1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Fred W. Bensel  |  |                  |   |   |   |   |  |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>April 24, 1982  |  |                 |  | 2b. HOUR<br>M |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White |   | 5. DATE OF BIRTH MONTH DAY YEAR<br>January 27, 1893 |   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>89 YRS  |   |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  | IF UNDER 24 HRS |  |               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County, MD. |   |  |                 |  |               |  |
| 10. CITY OR TOWN OF DEATH<br>Mt. Washington   |  |                  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>2601 Smith Avenue |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Optician   |  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Eye Glasses              |   |  |                 |  |               |  |
| 13a. STATE<br>Maryland  |  |                  | 13b. COUNTY<br>Baltimore  |   | 13c. CITY OR TOWN<br>Mt. Washington                               |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS<br>2601 Smith Avenue                      |   |  |                 |  |               |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>John Bensel  |  |                  |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Louisa Lauschke     |   |  |   |   |   |  |                 |  |               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>Yes  |  |                  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br>WW I  |   | 17. INFORMANT ADDRESS<br>Miss Dorothy M. Bensel 2601 Smith Avenue |   |  |   |   |   |  |                 |  |               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u><br>4409 DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Venous stasis + myocardial</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>(c) <u>Arteriosclerosis vasculi</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>acute</u><br><u>2 yrs</u><br><u>10 yrs</u> |  |                  |   |   |   |   |  |   |   | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><u>stomach ulcers, urinary tract obstr., generalized calcemia, T.I.A.</u> |  |                 |  |               |  |
| 19a. DATE OF OPERATION  |  |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |   |   |  |                 |  |               |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |   |   |  |                 |  |               |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |   |   |  |                 |  |               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6/5</u> 19 <u>76</u> to <u>4-24</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>4-20</u> 19 <u>82</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |                  |   |   |   |   |  |   |   | 22b. SIGNATURE DEGREE<br><u>H. Gerard Oster M.D.</u><br>22c. DATE SIGNED<br><u>4-26-82</u>  |  |                 |  |               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>H. Gerard Oster</u>   |  |                  | 22e. ADDRESS<br>3635 Old Court Road   |   |   |   |  |   |   |   |  |                 |  |               |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |                  | 23b. DATE<br>4-27-1982  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Parkwood                    |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore Maryland                                |   |   |   |  |                 |  |               |  |
| 24. FUNERAL DIRECTOR NAME<br>Ruck Towson Funeral Home, Inc.   |  |                  | ADDRESS<br>1050 York Road   |   |   | 25a. DATE REC'D. BY REGISTRAR<br>APR 27 1982  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Jan Nathan</u>   |   |   |  |                 |  |               |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |                     |  | 8 2 0 8 5 1 7                                |     |       |          |
|---|--|--|--|--|--|---|--|---------------------|--|--|-----|-------|----------|
| 1. FOR STATE REGISTRAR  |  | REG. NO.   |  |  |  |   |  |                     |  |  |     |       |          |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST  |  | MIDDLE   |  | LAST  |  | 2a. DATE OF DEATH   |  | MONTH  | DAY | YEAR  | 2b. HOUR |
| EVELYN  |  | BENSON   |  |  |  |   |  | April 13, 1982      |  |  |     |       | 6:20p M  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR     |  | IF UNDER 24 HRS.                             |     |       |          |
| Female  |  | White  |  | July 3, 1914   |  | 67  |  | YRS.                |  | MONTHS                                       |     | DAYS  |          |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                     |  |  |     |       |          |
| England   |  | U. S. A.   |  |  |  | Baltimore County  |  |                     |  |  |     | MD.   |          |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                     |  |  |     |       |          |
| Randallstown  |  | Baltimore County General   |  | Sales Lady   |  | Retail  |  |                     |  |  |     |       |          |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS |  |  |     |       |          |
| Maryland  |  | Baltimore  |  | Woodlawn   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 2025 Hillside Drive |  |  |     |       |          |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |   |  |                     |  |  |     |       |          |
| Herbert Barrett   |  | Edith Cave   |  |  |  |   |  |                     |  |  |     |       |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | ADDRESS   |  |                     |  |  |     |       |          |
| No  |  | 215,03 3527  |  | Joseph E. Benson   |  | same  |  |                     |  |  |     |       |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |   |  |                     |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |     |       |          |
| PART I. DEATH WAS CAUSED BY:  |  |  |  |  |  |   |  |                     |  |  |     |       |          |
| IMMEDIATE CAUSE (a)   |  |  |  |  |  |   |  |                     |  | 1 week                                       |     |       |          |
| 4292  |  |  |  |  |  |   |  |                     |  |  |     |       |          |
| DUE TO, OR AS A CONSEQUENCE OF:   |  |  |  |  |  |   |  |                     |  | 5 years                                      |     |       |          |
| Severe chronic obstructive pulmonary disease  |  |  |  |  |  |   |  |                     |  |  |     |       |          |
| DUE TO, OR AS A CONSEQUENCE OF:   |  |  |  |  |  |   |  |                     |  | 5 years                                      |     |       |          |
| Arteriosclerotic cardiovascular disease   |  |  |  |  |  |   |  |                     |  |  |     |       |          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |  |  |  |   |  |                     |  |  |     |       |          |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |                     |  |  |     |       |          |
|   |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |                     |  |  |     |       |          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |                     |  |  |     |       |          |
|   |  | HOUR A.M. MONTH DAY YEAR   |  |  |  |   |  |                     |  |  |     |       |          |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION  |  | CITY OR TOWN  |  | COUNTY              |  | STATE  |     |       |          |
| WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  |  | STREET   |  |   |  |                     |  |  |     |       |          |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 77 to Present 19, that (I) (we) last saw the deceased alive on March 15 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |                     |  |  |     |       |          |
| 22b. SIGNATURE  |  | DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  | 22c. DATE SIGNED  |  |                     |  |  |     |       |          |
| Dr. W. H. Townshend Jr  |  | MD   |  |  |  | 4/15/82   |  |                     |  |  |     |       |          |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |  |  |   |  |                     |  |  |     |       |          |
| Dr. W. H. Townshend Jr  |  | 14 E. Eager Street   |  |  |  |   |  |                     |  |  |     |       |          |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION   |  | CITY OR TOWN        |  | COUNTY                                       |     | STATE |          |
| Burial  |  | 17 Apr 1982  |  | Louden Park  |  | Baltimore   |  | Maryland            |  |  |     |       |          |
| 24. FUNERAL DIRECTOR  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |                     |  |  |     |       |          |
| Burgee Funeral Home, Baltimore, Maryland  |  | APR 15 1982  |  | Eugene J. [Signature]  |  |   |  |                     |  |  |     |       |          |

1811

April 17, 1952

RECEIVED

MAIL

Female

White

July 2, 1914

67

Albion County

C. F. A.

Female

White

Albion County

Albion County

Female

Albion County

Albion County

Female

White

Female

Case

Albion County

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Albion County

Albion County

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item 7a g567 5/12/82 gj

1- STATE REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 5 1 8

REG. NO.

|  |   |  |  |  |  |
|--|---|--|--|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>Ann Berenter   |   | 2a DATE OF DEATH<br>April 29, 1982   |  | 2b HOUR<br>5:37 P.M.   |  |
| 3 SEX<br>Female  | 4 RACE<br>White   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12 2 1897  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>84 YRS                                       |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>PA   | 7b CITIZEN OF WHAT COUNTRY?<br>U.S. America   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                    |  |
| 10 CITY OR TOWN OF DEATH<br>Catonsville  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Forest Heaven Nursing Home |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>house wife                  |  | 12b KIND OF BUSINESS OR INDUSTRY<br>own home |
| 13a STATE<br>D.C.  | 13b COUNTY<br>Washington  | 13c CITY OR TOWN<br>Washington   | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e STREET ADDRESS<br>2636 16th. St. N. W.                                     |  |
| 14 FATHER'S NAME<br>Simon  | 15. MOTHER'S MAIDEN NAME<br>Minnie  | 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No  |  |  |  |
| 16b SOCIAL SECURITY NO.<br>577 58 9222   |   | 17. INFORMANT<br>Mrs. Jack Schneider Ch. Chase Md.   |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>sepsis</u><br><u>4360</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Decubitus ulcers - recurrent</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Multiple Cerebrovascular accident</u>   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |   |  |  |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/26</u> , 19 <u>82</u> , to <u>4/29</u> , 19 <u>82</u> , that (I) (we) lost<br>saw the deceased alive on <u>4/26</u> , 19 <u>82</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death. |   |  |  |  |  |
| 22b. SIGNATURE<br><u>Harold Bob</u>  |   | DEGREE<br>MD   |  | 22c. DATE SIGNED<br>4/30/82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Harold Bob, M.D.  |   | 22e. ADDRESS<br>7220 Park Heights Ave. Baltimore, Md. 21208  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |   | 23b. DATE<br>5-2-82  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Lebanon Cem.                         |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Adelphi Pr. Geo. MD.   |   | 24. FUNERAL DIRECTOR<br><u>Warner E. Pumphrey Inc.</u><br>8434 Ga. Ave. Sil. Spr. Md.  |  |  |  |
| 25a. DATE REC'D. BY REGISTRAR<br>MAY 6 1982  |   | 25b. REGISTRAR'S SIGNATURE<br><u>James J. Nathan</u>   |  |  |  |

BP

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |  |  | 8 2 0 8 5 1 9<br>REG. NO.                    |  |
|--|--|--|--|---|--|---|--|--|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST MIDDLE LAST<br>HYMAN BERGER   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>4 18 82                            |  | 2b. HOUR<br>12:30 AM   |  |  |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>2 28 99   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>82x 83 YRS.                            |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS<br>HOURS MIN.                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>POLAND  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.              |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>TOWSON  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>GBMC-6701 N. CHARLES STREET |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>OWNER |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>REAL ESTATE   |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MARYLAND   |  | 13c. CITY OR TOWN<br>BALTIMORE   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br>6711 PARK HTS. AVE.                                |  | APT. 204   |  | 21215  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>ISAAC BERGER   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>SARAH YELLIN  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>219-32-1490                                   |  | 17. INFORMANT<br>MRS. MARION BERGER  |  | #21215                                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):<br>PART 1. DEATH WAS CAUSED BY:<br>5140 IMMEDIATE CAUSE (a) CARDIAC ARREST<br>PULMONARY EDEMA<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c) DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 4-2-82 19 82, to 4-18 19 82, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 4-18 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> (we) did not view the body after death. |  |  |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br>X Dr. B. Grubb   |  |  |  | DEGREE  |  |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>4-18-82                  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DR. B. GRUBB  |  |  |  | 22e. ADDRESS<br>6701 N. CHARLES STREET  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  | 23b. DATE<br>APR. 19, 1982   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>RUDOMER VEREIN  |  | 23d. LOCATION<br>ROSEDALE BALTO. MD                                       |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME SOL LEVINSON & BROS., INC.<br>6010 REISTERSTOWN RD. BALTO., MD 21215  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>APR 21 1982                              |  | 25b. REGISTRAR'S SIGNATURE<br>Frances Jean Nathan  |  |  |  |

1858-1859

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1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 5 2 0  
REG. NO.

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Elizabeth Mary Berk</b>  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>04 12 82</b>  |  | 2b. HOUR<br><b>12:30 PM</b>  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>01 09 1910</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>72</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rosedale</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>6914 Golden Ring Road</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Homemaking</b>   |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Rosedale</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 13e. STREET ADDRESS<br><b>6914 Golden Ring Road 21237</b>  |  | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Frederick Bohlen</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Minnie A Hawkins</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  |
| 16b. SOCIAL SECURITY NO.<br><b>217-60-4034</b>   |  | 17. INFORMANT<br><b>Shirley Robertson</b>   |  | ADDRESS<br><b>8607 McDaniel Avenue</b>  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac standstill</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>A.S.H.D.</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerosis</b>   |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost<br>saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Salmon</b>  |  | DEGREE<br><b>M.D.</b>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br><b>4-12-82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Samuel Steen M.D.</b>  |  | 22e. ADDRESS<br><b>285 Rigoo Rd</b>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>4/15/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Zion Luth. Cem. Golden Ring</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore MD.</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Lassahn Funeral Home</b>  |  | ADDRESS<br><b>7401 Belair Road</b>  |  | 25. DATE REC'D. BY REGISTRAR<br><b>APR 19 1982</b>  |  |  |  |

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DHMH - 16 50M 1/B1  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |                         |  |   |   |   |  |  |   | 8 2 0 8 5 2 1<br>REG. NO.  |  |  |  |                            |  |
|---|--|-------------------------|--|---|---|---|--|--|---|--|--|--|--|----------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>LOUISE P. BERRY</b>  |  |                         |  |   |   |   |  |  |   | 2b. DATE OF DEATH<br>MONTH <b>4</b> DAY <b>24</b> YEAR <b>82</b>   |  |  |  | 2b. HOUR<br><b>1912 PM</b> |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>Black</b> |  | 5. DATE OF BIRTH<br>MONTH <b>4</b> DAY <b>12</b> YEAR <b>1923</b>     |   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>59</b> |  |   | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>   |  | IF UNDER 24 HRS<br>HOURS <b>0</b> MIN. <b>0</b>                                  |  |                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>South Carolina</b>  |  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County MD.</b>                             |  |  |  |  |                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>  |  |                         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Balto., County General Hosp.</b> |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Ret. Counselor</b>   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Baltimore County</b>                                    |  |  |  |  |                            |  |
| 13a. STATE<br><b>Maryland</b>   |  |                         | 13b. COUNTY<br><b>Baltimore</b>  |   |   | 13c. CITY OR TOWN<br><b>Reisterstown</b>  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  | 13e. STREET ADDRESS<br><b>21 Woodholme Village Ct. Balto. Co. Maryland 21208</b> |  |                            |  |
| 14. FATHER'S NAME<br>FIRST <b>Warren</b> MIDDLE <b></b> LAST <b>Pyles</b>   |  |                         |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Bessie</b> MIDDLE <b></b> LAST <b>Starks</b> |   |  |  |   |  |  |  |  |                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  |                         |  |   | 16b. SOCIAL SECURITY NO.<br><b>189-16-6511</b>                                    |   |  |  |   | 17. INFORMANT <b>Balto. Co. Md. Village Court</b><br><b>Mr. Walthall M. Berry 21 Woodholme</b>   |  |  |  |                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4100 ACUTE MYOCARDIAL INFARCTION</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b></b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b> |  |                         |  |   |   |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b></b>  |  |  |  |                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |                         |  |   |   |   |  |  |   |  |  |  |  |                            |  |
| 19a. DATE OF OPERATION  |  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                      |   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |  |  |  |                            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>     |   |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) |   |  |  |  |  |                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |                         |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY OFFICE, FARM, ETC.) |   |   |  | 21i. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |  |  |  |  |                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |                         |  |   |   |   |  |  |   |  |  |  |  |                            |  |
| 22b. SIGNATURE<br><b>HAFEEZ A SYED (M.D.)</b>   |  |                         |  |   |   |   |  | DEGREE<br><b></b>  |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>4/24/82</b>   |  |                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>HAFEEZ A SYED (M.D.)</b>  |  |                         |  |   |   |   |  | 22e. ADDRESS<br><b>BALTIMORE COUNTY GEN HOSP</b>                               |   |  |  |  |  |                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Entombment</b>   |  |                         |  | 23b. DATE<br><b>4/29/82</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge Cemetery</b>   |  |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore County, Maryland</b>  |  |  |  |                            |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Baltimore</b> ADDRESS <b>Maryland 21216</b><br><b>Herbert E. Nuttall Funeral Home 3035 W. NORTH AVE</b>   |  |                         |  |   |   |   |  | 25a. DATE REC'D BY REGISTRAR<br><b>APR 28 1982</b>                             |   | 25b. REGISTRAR'S SIGNATURE<br><b>James J. North</b>  |  |  |  |                            |  |

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APR 28 1952

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| #1, Film G567 5/14/82 kam   |  |   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  | 8 2 0 8 5 2 2  |  |
|---|--|---|--|---|--|--|--|
| 1- FOR STATE REGISTRAR  |  |   |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Irving Frederick Bertholdt   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>April 14, 1982   |  | 2b. HOUR<br>7:45 PM  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Sept. 23, 1911  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>70 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Rossville  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Franklin Square Hospital |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Printer   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Sun Papers  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br>Maryland   |  |   |  | 13b. CITY OR TOWN<br>Baltimore  |  | 13c. STREET ADDRESS<br>3123 Woodring Ave.  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Conrad Bertholdt  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Ida Miller   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE YEAR OR DATES)<br>WW II   |  | 17. INFORMANT<br>ADDRESS<br>Lydia A. Bertholdt 3123 Woodring Ave.   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Myocardial</u><br><u>4100</u> DUE TO, OR AS A CONSEQUENCE OF <u>infarction</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary atherosclerosis</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>12 yrs</u> |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Sudden</u>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1965</u> , to <u>4/14/1982</u> , that (I) (we) last saw the deceased alive on <u>3/13/1982</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><u>William F. Renner</u>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br>4/16/82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>William F. Renner, M.D.  |  |   |  | 22e. ADDRESS<br>3222 St. Paul Street Baltimore, Md.   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>Apr. 19, 1982  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Parkwood  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Leonard J. Ruck, Inc. Baltimore, Maryland   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>APR 16 1982  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Frances VanNathan</u>   |  |

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## STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 5 2 3

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |   |  |   |   |   |   |  |   |  |
|--|--|---|--|---|---|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>SISTER Mary Edmund Bialek</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4 16 82</b>  |   |   | 2b. HOUR<br><b>10:20 P M</b>  |   |  |   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 20 07</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b> YRS.   |   | 7. BALTIMORE CITY OR COUNTY OF DEATH<br><b>County</b> MD   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Baltimore</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>County</b> MD  |   |  | 10. BALTIMORE CITY OR COUNTY OF DEATH<br><b>County</b> MD |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Mercy Villa</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housework</b>                          |   | 12b. KIND OF BUSINESS OR INDUSTRY  |   |  |
| 13a. STATE<br><b>Maryland</b>  |  |   | 13b. COUNTY<br><b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>                     |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>6806 Bellona Ave</b>            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joseph Bialek</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Katherine Lebdomicz</b>  |   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b> |   |  | 16b. SOCIAL SECURITY NO.<br><b>220-54-8723</b>            |  |
| 17. INFORMANT<br>ADDRESS<br><b>Sr. M. Elaine Costello 6806 Bellona AVE</b>   |  |   | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>atherosclerotic myocardial infarction</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>atherosclerosis</b> |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |  |   |  |   |   |   |   |  |   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                     |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>   |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____ 19_____, to _____ 19_____, that (I) (we) last saw the deceased alive on _____ 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |  |   |   |   |   |  |   |  |
| 22b. SIGNATURE<br><b>E. NARODIA</b>  |  |   |  |   |   | DEGREE  |   | 22c. DATE SIGNED   |   |  |
| 22d. PHYSICIAN'S NAME (ENTER COMPLETE)<br><b>E. NARODIA</b>  |  |   |  |   |   | 22e. ADDRESS<br><b>2300 Johns Valley Rd</b>   |   | 22f. ADDRESS<br><b>21209</b>   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |   | 23b. DATE<br><b>4/19/82</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn Cmt</b> |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto County Md</b>                            |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Watchell-Kedzie Home</b>  |  |   |  |   |   | ADDRESS<br><b>6500 York Rd</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 19 1982</b>  |   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Thomas J. ...</b>   |  |   |  |   |   |   |   |  |   |  |

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13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150 151 152 153 154 155 156 157 158 159 160 161 162 163 164 165 166 167 168 169 170 171 172 173 174 175 176 177 178 179 180 181 182 183 184 185 186 187 188 189 190 191 192 193 194 195 196 197 198 199 200

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901 902 903 904 905 906 907 908 909 910 911 912 913 914 915 916 917 918 919 920 921 922 923 924 925 926 927 928 929 930 931 932 933 934 935 936 937 938 939 940 941 942 943 944 945 946 947 948 949 950 951 952 953 954 955 956 957 958 959 960 961 962 963 964 965 966 967 968 969 970 971 972 973 974 975 976 977 978 979 980 981 982 983 984 985 986 987 988 989 990 991 992 993 994 995 996 997 998 999 1000

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1101 1102 1103 1104 1105 1106 1107 1108 1109 1110 1111 1112 1113 1114 1115 1116 1117 1118 1119 1120 1121 1122 1123 1124 1125 1126 1127 1128 1129 1130 1131 1132 1133 1134 1135 1136 1137 1138 1139 1140 1141 1142 1143 1144 1145 1146 1147 1148 1149 1150 1151 1152 1153 1154 1155 1156 1157 1158 1159 1160 1161 1162 1163 1164 1165 1166 1167 1168 1169 1170 1171 1172 1173 1174 1175 1176 1177 1178 1179 1180 1181 1182 1183 1184 1185 1186 1187 1188 1189 1190 1191 1192 1193 1194 1195 1196 1197 1198 1199 1200

1201 1202 1203 1204 1205 1206 1207 1208 1209 1210 1211 1212 1213 1214 1215 1216 1217 1218 1219 1220 1221 1222 1223 1224 1225 1226 1227 1228 1229 1230 1231 1232 1233 1234 1235 1236 1237 1238 1239 1240 1241 1242 1243 1244 1245 1246 1247 1248 1249 1250 1251 1252 1253 1254 1255 1256 1257 1258 1259 1260 1261 1262 1263 1264 1265 1266 1267 1268 1269 1270 1271 1272 1273 1274 1275 1276 1277 1278 1279 1280 1281 1282 1283 1284 1285 1286 1287 1288 1289 1290 1291 1292 1293 1294 1295 1296 1297 1298 1299 1300

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 5 2 4

REG. NO.

|  |  |  |   |   |  |   |  |  |  |
|--|--|--|---|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>CLARENCE E. BIRCH Jr</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4-27-82</b>                 |   |  | 2b. HOUR<br><b>10<sup>25</sup> A M</b>  |  |  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 18 07</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>74</b> YRS  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE<br>(COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY, MD.</b>                            |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>MULTI-MEDICAL CENTER</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>V.P. General Auto</b>    |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Oil Burner C.</b>  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>Towson</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>401 Alabama Road</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Clarence E. Birch, Sr.</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Laura V. Dumm</b> |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>213-10-8977</b>   |   | 17. INFORMANT ADDRESS<br><b>Ida A. Birch, Same As #13e</b>  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Sepsis + GI Bleeding</b><br><b>4360</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) <b>(B) CVA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Aortic Valve Stenosis + replacement</b> |  |  |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:   |  |  |   |   |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>12/21/81</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Aortic Stenosis</b>   |   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT OR UNDERLYING OR CONTRIBUTING CAUSE OF DEATH<br>(IF OTHER, NOTIFY MEDICAL EXAMINER)<br><input type="checkbox"/> CAUSE OF DEATH<br><input type="checkbox"/> OTHER   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4/27/82</b> to <b>4/27/82</b> that (I) (we) last saw the deceased alive on <b>4/27/82</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |  |   |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Alan Shorofsky MD</b>   |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |   |  | 22c. DATE SIGNED<br><b>4/27/82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ALAN SHOROFKY, MD</b>  |  |  |   | 22e. ADDRESS<br><b>1708 Whitehead Rd Balt 21207</b>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>  |  | 23b. DATE<br><b>4-28-82</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Crematory</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>                         |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Ruck Towson Funeral Home, Inc. Towson, Md. 21204</b>  |  |  |   | ADDRESS<br><b>1050 York Rd.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 29 1982</b>   |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81  
(VRA 15, 4)STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 5 2 5

REG. NO.

|   |  |   |  |   |  |  |  |   |  |
|---|--|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>WILLIAM F. BITZ</b>  |  |   |  | 2a. DATE OF DEATH<br>MONTH <b>4</b> DAY <b>14</b> YEAR <b>82</b>  |  |  |  | 2b. HOUR<br><b>4:02</b> P.M.  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>1</b> DAY <b>6</b> YEAR <b>1909</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b> YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS <b>4</b> DAYS <b>14</b> HOURS <b>02</b> MIN.                       |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>MD</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                                    |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore County General Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Draftsman</b>                   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Bendix</b>  |  |
| 13a. STATE<br><b>MD</b>   |  |   |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Pikesville</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST <b>Franklin</b> MIDDLE <b>Walter</b> LAST <b>Bitz</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Anna</b> MIDDLE <b>C.</b> LAST <b>Rutger</b>   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>705-05-7368</b>  |  | 17. INFORMANT<br>NAME <b>Mrs. Alma S. Bitz</b> ADDRESS <b>7019 Plymouth Road, Pikesville, MD 21208</b> |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>VENTRICULAR ARRHYTHMIA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>PULMONARY EDEMA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>RENAL FAILURE WITH HYPERTENSION</b> |  |   |  |   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b><br><b>DIGOXIN TOXICITY; ANEMIC ENCEPHALOPATHY; 2° RENAL FAILURE</b>   |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                        |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                         |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4-3-82</b> to <b>4-14-82</b> , that (I) (we) lost<br>saw the deceased alive on <b>4-14-82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>[Signature]</b>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |  |  | 22c. DATE SIGNED<br><b>4-14-82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BERNARDO B. CONNAN, MD</b>  |  |   |  | 22e. ADDRESS<br><b>BEGH-RANDALLSTOWN Md. 21133</b>  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |   |  | 23b. DATE<br><b>4/17/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Woodlawn Baltimore MD</b>                      |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Loring Byers Funeral Directors, Inc.</b> ADDRESS <b>8728 Liberty Rd., Randallstown, MD 21133</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 16 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |   |  |

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*[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side. The text is mostly horizontal and spans the width of the page.]*

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 5 2 6

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |   |  |   |  |   |  |  |
|---|--|---|--|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>ESTHER LEE BLACK   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>April 23, 1982                  |   | 2b. HOUR<br>12:10 P.M.   |   |  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Feb. 25, 1906   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>76 YRS.                    |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Towson   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>911 Southerly Avenue |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Bookkeeper  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Balto. City              |  |  |
| 13a. STATE<br>Maryland  |  |   | 13b. COUNTY<br>Baltimore   |   | 13c. CITY OR TOWN<br>Towson  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Edgar Wamsley   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Clara Burgess         |   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>212 07 0475 |   | 17. INFORMANT<br>ADDRESS<br>William Garrison, Balto., Md. 21211                      |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>metastatic Adenocarcinoma of</u><br><u>1579</u><br>DUE TO, OR AS A CONSEQUENCE OF <u>Pancreas</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF _____<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |   |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 10, 1982</u> to <u>April 23, 1982</u> that (I) (we) lost<br>saw the deceased <u>4/21</u> 19 <u>82</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |   |  |  |
| 22b. SIGNATURE<br><u>B.K. Yorkoff, M.D.</u>   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br><u>7/23/82</u>                            |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Benjamin K. Yorkoff, M.D.  |  |   |  | 22e. ADDRESS<br>7401 Osler Drive, Towson, Md. 21204   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>4/26/82  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Moreland  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. Co., Md. |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Henry W. Jenkins & Sons Co.<br>4905 York Road Balto., Md. 21212   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>APR 26 1982  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Frances Jean Northern</u>    |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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April 12, 1951

Baltimore County

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| FOR<br>STATE<br>REGISTRAR   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |   | 8 2 0 8 5 2 7<br>REG. NO.  |  |
|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Robert James Blewitt</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 1, 1982</b>                             |  | 2b. HOUR<br>M<br><b>AM</b>   |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Jan. 24 1914</b>   |   | 6. AGE<br>(IN YEARS LAST BIRTHDAY)<br><b>68</b>                                      | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.     |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Franklin, W. Va.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b><br>MD                |  |
| 10. CITY OR TOWN OF DEATH<br><b>Essex 21221</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT, GIVE STREET ADDRESS)<br><b>626 Back River Neck Rd.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF OCCUPATION OR MOST OF WORKING LIFE)<br><b>Painter</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>General Motors</b>           |
| 13a. USUAL RESIDENCE<br>(IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |  |   | 13b. COUNTY<br><b>Baltimore</b>   | 13c. CITY OR TOWN<br><b>Essex 21221</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>W. Pent Blewitt</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Daisy Thompson</b>                  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>236 20 9825</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Pearl Blewitt, Wife Same</b>                          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary H. Ventricular Fibrillation</b><br><b>4140</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Complete heart failure, severe</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>MSAHD</b> |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>6 months year</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>Bladder tumor</b>  |  |   |   |  |  |
| 19a. DATE OF OPERATION<br><b>Cystoscopy</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Bladder tumor</b>  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Dec 11</b> , 19 <b>81</b> , to <b>3-14</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.   |  |   |   |  |  |
| 22b. SIGNATURE<br><b>Leopoldo Gruss</b><br>DEGREE<br><b>M.D.</b>  |  |   |   | 22c. DATE SIGNED<br><b>4-2-82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Leopoldo Gruss M.D.</b>   |  |   |   | 22e. ADDRESS<br><b>405 Stemmers Run Rd</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>Burial</b>  |  | 23b. DATE<br><b>4/5/82</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardens of Faith Cemetery</b>               |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co., Md.</b>   |  |   |   |  |  |
| 24. FUNERAL DIRECTOR<br><b>Brudzinski Funeral Home</b>  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 2 1982</b>                                   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>James J. Thirion</b>   |  |   |   |  |  |

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*[Faint handwritten notes]*

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR  |  |   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 8 2 0 8 5 2 8<br>REG. NO.   |  |  |  |
|--|--|---|--|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>MARY BLOCK  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>APRIL 22, 1982   |  |  |  | 2b. HOUR P.<br>3:30 M.  |  |  |  |
| 3 SEX<br>FEMALE  |  | 4 RACE<br>WHITE   |  | 5 DATE OF BIRTH MONTH DAY YEAR<br>10 14 1905   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>76 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.  |  |   |  |  |  |
| 10 CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>130 SLADE AVE., APT. 417 |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE                                    |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>AT HOME  |  |  |  |
| 13a. STATE<br>MARYLAND   |  |   |  | 13b. COUNTY<br>BALTO.  |  | 13c. CITY OR TOWN<br>BALTIMORE   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>130 SLADE AVE., APT. 417 #21208   |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>ABRAHAM GREENSTEIN   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>FANNIE LEVENSTEIN  |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO   |  |   |  | 16b. SOCIAL SECURITY NO.<br>219-32-7087  |  | 17 INFORMANT ADDRESS<br>ESTATE OF MARY BLOCK, WILBUR C. JENSEN<br>40 WEINBERG & GREENE 100 S. CHARLES ST. #21201 |  |   |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Cardiac arrest</u><br>4292<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>ICVD</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____   |  |   |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Peptic ulcer</u>  |  |   |  |  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION<br>3/12/82  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/12/82</u> 19 <u>82</u> , to <u>4/1/82</u> 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>3/31/82</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Stanley R. Steinback M.D.</u> DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  |   |  |  |  |  |  |   |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>STANLEY R. STEINBACK M.D.   |  |   |  | 22e. ADDRESS<br>11 SLADE AVE. BALTO., MD 21208   |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  |   |  | 23b. DATE<br>APR. 25, 1982   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>ANSHE EMUNAH-AITZ CHA  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE MARYLAND                                |  |  |  |
| 24 FUNERAL DIRECTOR NAME<br>SOL LEVINSON & BROS., INC.<br>6010 REISTERSTOWN RD. BALTO., MD 21215   |  |   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>APR 28 1982   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Jan Nathan</u>   |  |  |  |

0 2 2 8 6 0

1975 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

1975 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

APR 28 1975

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 2 0 8 5 2 9  
REG. NO.

|  |  |   |   |   |                            |   |  |
|--|--|---|---|---|----------------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>EDGAR Carlton BOARD</b> |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4-10-82</b> |   | 2b. HOUR<br><b>12:55PM</b> |   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9 1 68</b>   |                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>13</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                           |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO County</b> MD.                                 |  |
| 10. CITY OR TOWN OF DEATH<br><b>Dwings Mills</b>                                       |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Rosewood Center</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>None</b>   |                            | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>   |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |                            | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joel Benjamin Board</b>                   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Norma Jane Hanby</b>  |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |                            | 16b. SOCIAL SECURITY NO.<br><b>212-78-4565</b>  |  |
| 17. INFORMANT <b>Parents:</b>  |  |   |   | ADDRESS<br><b>21202</b>   |                            | 18. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO County</b> MD.                                |  |

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b><br><b>4860</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>massive Pneumonitis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>ANOXIA</b> |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 days</b>                        |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>Mental Retardation (Severe)</b>  |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><b>N/A</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost<br>saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above; (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |
| 22a. SIGNATURE<br><b>Harriet L. Meier</b>   |  |  |  | 22c. DATE SIGNED<br><b>4/11/82</b>   |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Harriet L. Meier</b>  |  |  |  | 22e. ADDRESS<br><b>Rosewood Center</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>  |  | 23b. DATE<br><b>4/12/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Security Process</b>                        |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>STEWART &amp; MOWEN CO., 108 W. North Ave.</b>   |  | ADDRESS<br><b>21201</b>  |  | 25a. DATE REGD. BY REGISTRAR<br><b>APR 18 1982</b>                                   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Jan Nathan</b> MD  |  |  |  |  |  |

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Garling

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Home

James Earl Ray

James Earl Ray

James Earl Ray

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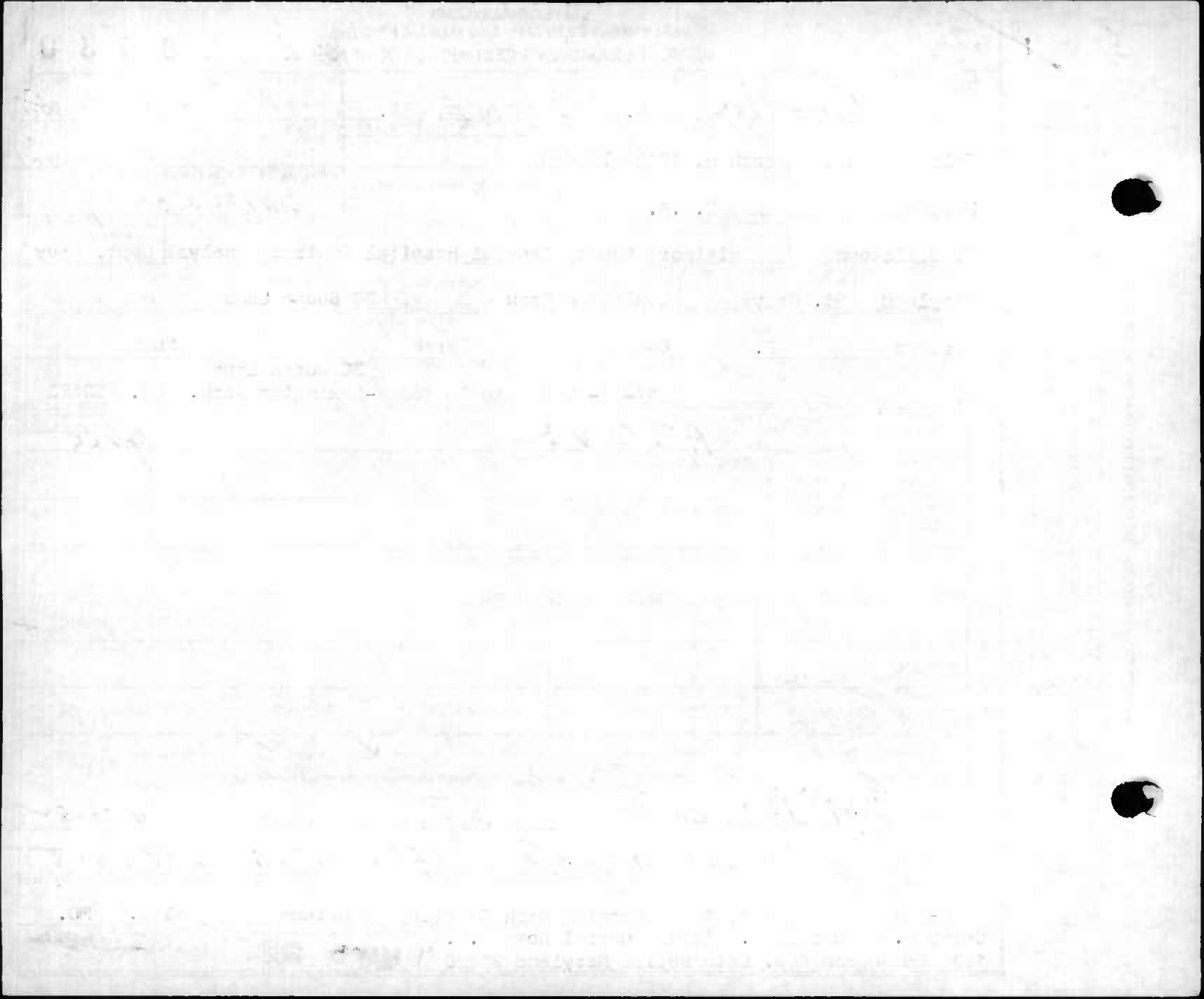
1972

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE ADVISE THE MEDICAL EXAMINER. WRITE THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP \_\_\_\_\_  
DHMH - 17  
(VR A15 ME (5))  
15M 7/77

| FOR<br>1- STATE<br>REGISTRAR  |         | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH |                   | REG. NO. 08530                                    |                     |
|---|---------|---|-------------------|---|---------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |         | FIRST MIDDLE LAST   |                   | 2a. DATE KNOWN OF DEATH                           |                     |
| Charles M. Boone, SR.   |         |   |                   | MONTH DAY YEAR 4 30 1982                          |                     |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH  | 6. AGE (IN YEARS) | 7. IF UNDER 1 YR.                                 | 7. IF UNDER 24 HRS. |
| Male  | White   | March 5, 1912   | 70 YRS.           | MONTHS DAYS                                       | HOURS MIN.          |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |         | 7b. CITIZEN OF WHAT COUNTRY?  |                   | 8. MARRIED  |                     |
| Maryland  |         | U.S.A.  |                   | NEVER MARRIED                                     |                     |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION  |                   | 12a. USUAL OCCUPATION (TYPE OF WORK)              |                     |
| Randallstown  |         | Baltimore County General Hospital   |                   | Contract Analyst                                  |                     |
| 13a. STATE  |         | 13b. COUNTY   |                   | 13c. CITY OR TOWN                                 |                     |
| Maryland  |         | St. Marys   |                   | Lexington Park                                    |                     |
| 14. FATHER'S NAME   |         | 15. MOTHER'S MAIDEN NAME  |                   | 16. SOCIAL SECURITY NO.                           |                     |
| Charles F. Boone  |         | Sarah Murk  |                   | 212-01-7966                                       |                     |
| 17. INFORMANT   |         | 18. CAUSE OF DEATH  |                   | 19. DATE OF OPERATION                             |                     |
| Adele Boone-Lexington Park, MD. 20653   |         | ASCVA   |                   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? |                     |
| 20. AUTOPSY?  |         | 21a. EXTERNAL CAUSE WAS   |                   | 21b. TIME OF INJURY                               |                     |
| YES [ ] NO [ ]  |         | UNDERLYING OR CONTRIBUTING CAUSE OF DEATH   |                   | HOUR A.M. MONTH DAY YEAR                          |                     |
| 22a. I certify that I took charge of the remains described above, held on                             |         | 22b. HOW INJURY OCCURRED  |                   | 22c. PLACE OF INJURY                              |                     |
| Autopsy [ ] Inspection [ ] Inquiry [ ] and in my opinion  |         | ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2  |                   | (AT HOME, STREET, FACTORY, FARM, ETC.)            |                     |
| death resulted from: Natural causes [ ] Accident [ ] Suicide [ ] Homicide [ ] Undetermined manner [ ] |         | 23a. BURIAL, CREMATION, REMOVAL   |                   | 23b. DATE   |                     |
| ACTUAL SIGNATURE: E. P. Williamson II   |         | Burial  |                   | May 3, 1982                                       |                     |
| TITLE (SPECIFY): M.D. Defery  |         | 23c. NAME OF CEMETERY OR CREMATORY  |                   | 23d. LOCATION                                     |                     |
| MEDICAL EXAMINER  |         | Lorraine Park Cemetery  |                   | CITY OR TOWN                                      |                     |
| DATE SIGNED: 4-30-82  |         | 24. FUNERAL DIRECTOR  |                   | COUNTY  |                     |
| EXAMINER'S NAME (TYPE OR PRINT): E. P. Williamson II  |         | Russell C. Wittke Funeral Home P.A.   |                   | STATE   |                     |
| ADDRESS: 1558 RALTON AVE PK 21228   |         | 1630 Edmondson Ave. Catonsville Maryland 21228  |                   | BALTO. MD.  |                     |
| 25a. DATE REC'D. BY REGISTRAR   |         | 25b. REGISTRAR'S SIGNATURE  |                   | 25c. DATE   |                     |
| MAY 5 1982  |         | J. P. [Signature]   |                   | MAY 5 1982  |                     |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |   |   |   |  |  | 8 2 0 8 5 3 1              |  |  |  |
|--|--|---|--|---|---|---|---|--|--|----------------------------|--|--|--|
| 1 - FOR STATE REGISTRAR  |  |   |  |   |   |   |   |  |  | REG. NO.                   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>ROBERT LEE BOWEN</b>  |  |   |  |   | 2a. DATE OF DEATH<br><b>April 22, 1982</b>  |   |   |  |  | 2b. HOUR<br><b>3:05a M</b> |  |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br><b>Jan. 8, 1903</b>   |   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b>                        |  | 7. UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN. |                            |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD. |  |  |                            |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rossville</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin-Square Hospital</b> |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Boiler Operator</b> |   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Steel Mfgr.</b>  |  |                            |  |  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Balto.</b>  |  | 13c. CITY OR TOWN<br><b>Dundalk</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>7019 Dunbar Rd. 21222</b>  |  |                            |  |  |  |
| 14. FATHER'S NAME<br>FIRST <b>Miletus</b> MIDDLE <b>Jarman</b> LAST <b>Bowen</b>   |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Mary</b> MIDDLE <b>Maupin</b> LAST <b>Maupin</b>   |   |   |  |  |                            |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>231.03.3638</b>  |  | 17. INFORMANT ADDRESS<br><b>Mary J. Bowen (Same as 13e)</b>   |   |   |   |  |  |                            |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>RESPIRATORY Arrest</b><br><b>4960</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>CHRONIC OBSTRUCTIVE PULMONARY Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c) <b>-8 YRS.</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 months</b> |  |   |  |   |   |   |   |  |  |                            |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>THYMOID, 2 LUNGS.</b>   |  |   |  |   |   |   |   |  |  |                            |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                            |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |   |  |  |                            |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |   |  |  |                            |  |  |  |
| 22a. I certify that (1) this hospital attended the deceased from <b>4-21</b> 19 <b>82</b> to <b>4-22</b> 19 <b>82</b> , that (2) the deceased died on <b>4-21</b> 19 <b>82</b> , and that in my (a) (b) opinion death occurred on the date and hour and from the causes stated above.  |  |   |  |   |   |   |   |  |  |                            |  |  |  |
| 22b. SIGNATURE<br><b>Norris L. Horwitz</b>   |  | DEGREE<br><b>MD</b>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |   | 22c. DATE SIGNED<br><b>4-22-82</b>  |   |  |  |                            |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>NORRIS L. HORWITZ MD</b>   |  |   |  | 22e. ADDRESS<br><b>611 PARK AVE. BALD. MD 21201</b>   |   |   |   |  |  |                            |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>4/26/1982</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Meadowridge Mem. Pk.</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Elkridge Maryland</b>                          |   |  |  |                            |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Walter Brooks Bradley Inc., Dundalk, Md. 21222</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 23 1982</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>James J. [Signature]</b>                                       |   |  |  |                            |  |  |  |

1 2 8 0 3 3

CHRONIC OBSTRUCTIVE PULMONARY DISEASE - 2 YRS  
FLEXIBILITY IMPAIRED

THINNING OF LUNG

Normal findings in all tests  
New findings -  
MD  
10-31-81  
4-11-82

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-368-5878.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 5 3 2

REG. NO.

1- STATE  
REGISTRAR

|  |  |   |  |   |  |  |  |  |  |
|--|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Alice C. Bowers</i>   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>7-25-82</i>   |  |  |  | 2b. HOUR<br><i>330 P.M.</i>  |  |
| 3. SEX<br><i>female</i>  |  | 4. RACE<br><i>white</i>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>6-26-86</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>95</i> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><i>Md.</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>BALTIMORE COUNTY MD.</i>  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>RANDALLSTOWN</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>RANDALLSTOWN NURSING HOME</i> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>HOUSE WIFE</i>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>SELF</i>   |  |
| 13a. STATE<br><i>MD.</i>   |  | 13b. COUNTY<br><i>BALTO.</i>  |  | 13c. CITY OR TOWN<br><i>PIKESVILLE</i>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS<br><i>809 TEMPLECLIFF RD. 21208</i>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>SAMUEL W. BROWN</i>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>AUGUSTA THOMAS</i>  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i>  |  | 16b. SOCIAL SECURITY NO.<br><i>220-44-0078</i>  |  | 17. INFORMANT<br><i>SAMUEL G. BOWERS</i>  |  | ADDRESS<br><i>126K CATALINA DR. LUSBY MD 20657</i>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><i>3109</i> IMMEDIATE CAUSE (a) <i>Natural Causes</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><i>Gravimic Brain Anomaly Devel</i>  |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>4:25 P.M. 1982</i>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>4/25</i> 19 <i>82</i> to <i>4/25</i> 19 <i>82</i> , that (I) (we) last saw the deceased alive on <i>4/25</i> 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.   |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><i>Robert Koopnick</i>   |  |   |  | DEGREE<br><i>MD.</i>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><i>4/26/82</i>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Robert Koopnick</i>  |  |   |  | 22e. ADDRESS<br><i>8726 Liberty Road</i>  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>BURIAL</i>  |  | 23b. DATE<br><i>4-27-82</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>CHESTER CEMETERY</i>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>CHESTERTOWN MD.</i>   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>FRANK H. NEWELL, INC.</i>   |  |   |  | ADDRESS<br><i>PIKESVILLE MD.</i>  |  | 25a. DATE REC'D. BY REGISTRAR<br><i>APR 27 1982</i>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Frances Jean Nathan</i>   |  |

BP

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 2 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |  |  | 8 2 0 8 5 3 3 |  |
|---|--|--|--|---|--|---|--|--|--|---------------|--|
| 1. FOR STATE REGISTRAR  |  | REG. NO.   |  |   |  |   |  |  |  |               |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Ethel C. Bowie</b>  |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4 - 12-82</b>   |  | 2b. HOUR<br><b>6:10</b> M  |  |               |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6 - 5 - 93</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>88</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Conn.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                             |  |  |  |               |  |
| 10. CITY OR TOWN OF DEATH<br><b>Catonsville</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Tawes Nursing Center</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>   |  |               |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>P.G.</b>   |  | 13c. CITY OR TOWN<br><b>Glenn Dale</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>9914 Worrell Ave.</b>  |  |               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles Benjamin</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Bertha Gilbert</b>  |  | 16. ADDRESS<br><b>Address Same as No# 13e.</b>  |  |  |  |               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>718-14-9866</b>   |  | 17. INFORMANT<br><b>Richard M. Bowie</b>  |  |   |  |  |  |               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial infarction</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Atherosclerotic Cardiovascular Disease.</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |   |  |  |  |               |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |               |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4-5-19-82</b> to <b>4-12-19-82</b> , that (I) (we) lost saw the deceased alive on <b>4-5-19-82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |  |  |  |               |  |
| 22b. SIGNATURE<br><b>D. Saluja</b>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |   |  | 22c. DATE SIGNED<br><b>4-12-82</b>   |  |               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DARSHAN S. SALUJA MD</b>  |  |  |  | 22e. ADDRESS<br><b>TAWES NH; Catonsville 21228</b>  |  |   |  |  |  |               |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>4-14-82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ft. Lincoln Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Brentwood P.G. Maryland</b>                    |  |  |  |               |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>F. Gasch's Sons F.H. P.A. Hyattsville, Md.</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 14 1982</b>   |  |   |  |  |  |               |  |

F. Speck's Sons L.L. P., Fayetteville, Mo.

4-14-92

Bureau

Ft. Lincoln Cemetery, Brentwood

T.O. Maryland

x

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 5 3 4

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|   |  |   |   |   |   |  |   |   |  |  |
|---|--|---|---|---|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>THOMAS BROGDON</b>                                |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>04 16 82</b>               |   | 2b. HOUR<br><b>11:40 P</b>  |  |   |   |  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>BLACK</b>   |   | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>10 20 04</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br><b>77</b>                                  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore Co. MD.</b>                   |   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>CATONSVILLE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SPRING GROVE HOSPITAL</b> |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Laborer</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY                               |  |  |
| 13a. STATE<br><b>MARYLAND</b>   |  |   | 13b. COUNTY<br><b>PRINCE GEORGE</b>                               |   | 13c. CITY OR TOWN<br><b>Willa Brogdon-daughter-4901 Just St. NE</b> |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>120 E MILL AVE</b> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>George Brogdon</b>  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Lara Brogdon</b> |   |   |  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>no</b> |  |   | 16b. SOCIAL SECURITY NO.<br><b>228-07-781</b>                     |   |   | 17. INFORMANT ADDRESS<br><b>Willa Brogdon-daughter-4901 Just St. NE</b>            |   |   |  |  |

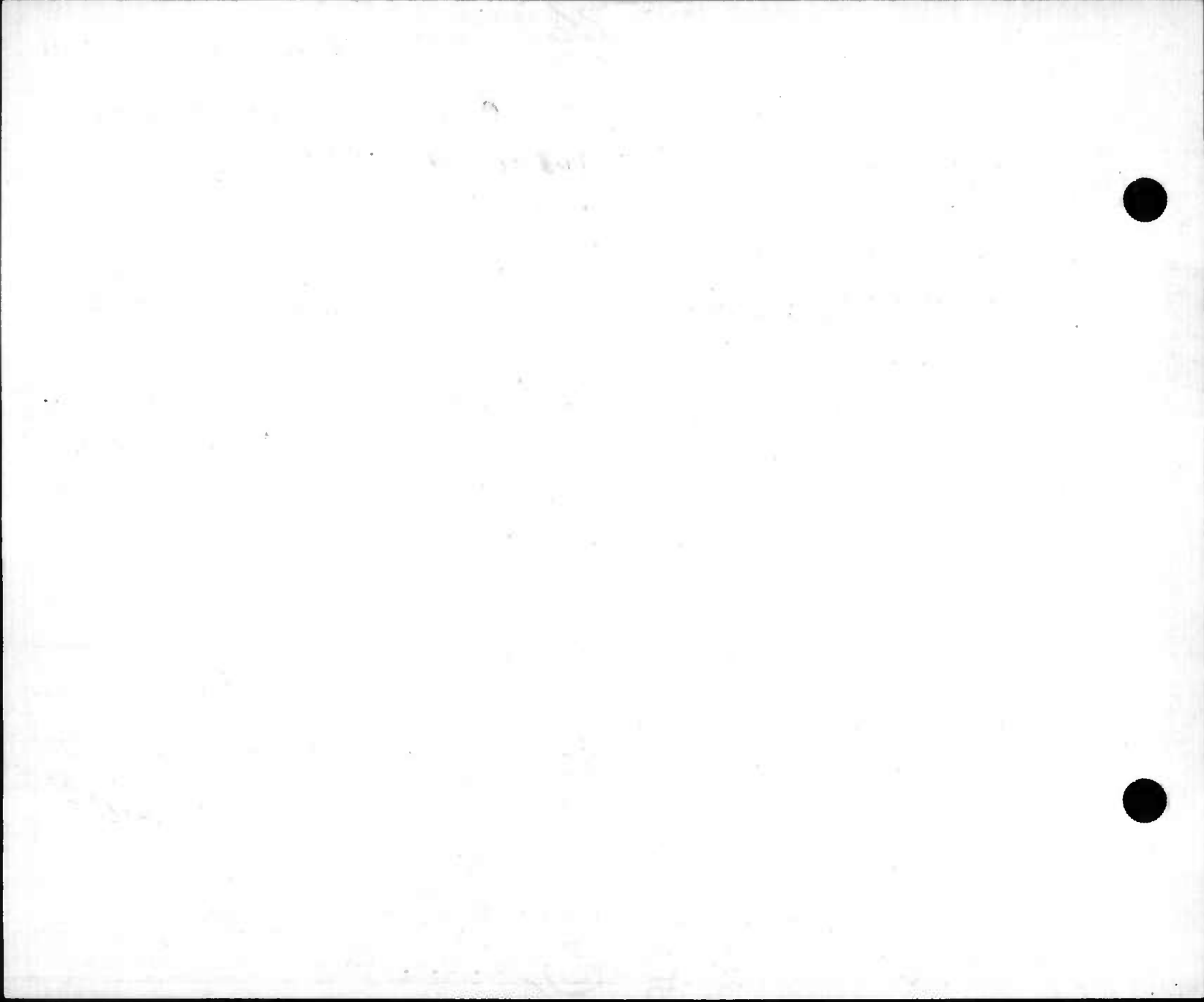
|  |  |   |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I: DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>ARTERIAL SCLEROTIC CARDIOVASCULAR DISEASE</b><br><b>4292</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>MALNUTRITION</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>DEHYDRATION</b> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>7 YEARS</b> |
|--|--|---|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

**GASTROENTERITIS, DEMENTIA**

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>APRIL 14</b> 19 <b>82</b> to <b>APRIL 16</b> 19 <b>82</b> , that (I) (we) last<br>saw the deceased alive on <b>APRIL 16</b> 19 <b>82</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Myun Kim</b>  |  |  |  | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>4-16-82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MYUN KIM, MD</b>   |  |  |  | 22e. ADDRESS<br><b>SPRING GROVE HOSPITAL</b>                                   |  |   |  |

|   |  |                                    |  |  |  |  |  |
|---|--|------------------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>               |  | 23b. DATE<br><b>April 22, 1982</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Family Cemetery Sax, Virginia</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE       |  |
| 24. FUNERAL DIRECTOR'S NAME<br><b>Stewart Funeral Home-4001 Benning Rd.</b> |  |                                    |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 26 1982</b>                        |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b> |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item #5&amp;6 per phone call w/Fun.

1. FOR Home 4/13/82 re  
STATE REGISTRARDEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 5 3 5

REG. NO.

|  |  |   |  |   |                            |  |
|--|--|---|--|---|----------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>IRVIN Lee BROMWELL</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>04 12 82</b>         |   | 2b. HOUR<br><b>4:08P M</b> |  |
| 1.5 SEX<br><b>Male</b>   |  | 4 RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8-1-1903</b>   |                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b><br>MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE</b> County MD.    |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>G.B.M.C. 6701 N. CHARLES STREET</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Rt. of way Agent</b>   |                            | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Railroad</b>                   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE <b>Maryland</b> 13c. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Baltimore</b> |  |   |  |   |                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Lee Bromwell</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Myrtle</b> |   |                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>705-05-7432</b>   |  | 17. INFORMANT ADDRESS<br><b>Richard L. Bromwell 14 Apache Ct 20878</b>  |                            |  |

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b><br><b>4275</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>ARREST UNWITNESSED</b><br>(c) <b>UNKNOWN</b>   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>UNKNOWN</b>                       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>CONGESTIVE HEART FAILURE</b>  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                         |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)        |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)                     |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>04-12-19-82</b> to <b>04-12-19-82</b> , that (I) (we) last saw the deceased alive on <b>04-12-19-82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Cheryl L. Dickason</b><br>THE PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. CHERYL L. DICKASON</b>   |  |   |  | 22c. DATE SIGNED<br><b>4/12/82</b>   |  |
| 22e. ADDRESS<br><b>GREATER BALTO. MEDICAL CENTER<br/>6701 N. CHARLES ST., BALTO., MD. 21204</b>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>   |  | 23b. DATE<br><b>4-16-82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Greenmount Cemetery</b>                     |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore</b>   |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Mitchell-Wiedefeld Home 6500 York Rd 21212</b> |  |  |  |
| 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR SIGNATURE<br><b>James J. Nathan</b>  |  |  |  |

BALTIMORE

TOWSON 6701 W. CHARLES STREET C.B.M.C. C.O. WAY 10000

ARREST UNWITNESSED

CONGESTIVE HEART FAILURE

X

04-15 83 04-15 83 04-15 83

DR. CHERYL L. DICKSON  
6701 N. CHARLES ST., BALTO., MD. 21204  
GREATER BALTO. MEDICAL CENTER

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 5 3 6

REG. NO.

|  |   |   |   |  |  |
|--|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Cora May Brown</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 9, 1982</b>                                     |  | 2b. HOUR<br><b>6.00 A.M.</b>   |
| 3. SEX<br><b>female</b>  | 4. RACE<br><b>white</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Sept. 5, 1895</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b> YRS.                                    | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br>IF UNDER 24 HRS.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>West Virginia</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Woodlawn</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>7727 Johnny Cake Road</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>housewife</b>            | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>at Home</b>                                  |  |
| 13a. STATE<br><b>Maryland</b>  | 13b. COUNTY<br><b>Baltimore</b>   | 13c. CITY OR TOWN<br><b>Woodlawn</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br><b>7727 Johnny Cake Road</b>                                  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Eugene Oates</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Annie Garner</b>  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>213 01 6897</b>   | 17. INFORMANT<br><b>7727 Johnny Cake Road</b><br><b>Garner A. Brown Woodlawn, Maryland 21227</b>  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>A.S.C.V.D.</b><br><b>4292</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |   |   |   |  | APPROXIMATE PERIOD BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |   |   |   |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5-13-</b> 19 <b>69</b> to <b>4-9</b> 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>4-5-</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) not view the body after death.             |   |   |   |  |  |
| 22b. SIGNATURE<br><b>Barby Calin</b>   |   | DEGREE<br><b>M.D.</b>   |   | 22c. DATE SIGNED<br><b>4-10-82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BARBY CALIN</b>  |   | 22e. ADDRESS<br><b>3459 St. John's Lane E.C. 21043</b>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>burial</b>  | 23b. DATE<br><b>4/12/82</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Good Shepherd Cem.</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Ellicott City, Howard, Maryland</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SLACK Funeral Home, Ellicott City, Maryland 21043</b>   |   | ADDRESS   |   | 25a. DATE RECD. BY REGISTRAR<br><b>APR 13 1982</b>                                   | 25b. REGISTRAR SIGNATURE<br><b>James J. Nathan</b>   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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John ... ..

White ... ..

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A 2 CVD

4-4-82

4-10-82

4-10-82

Barber

CHAIR

BARBER

APR 13 1982

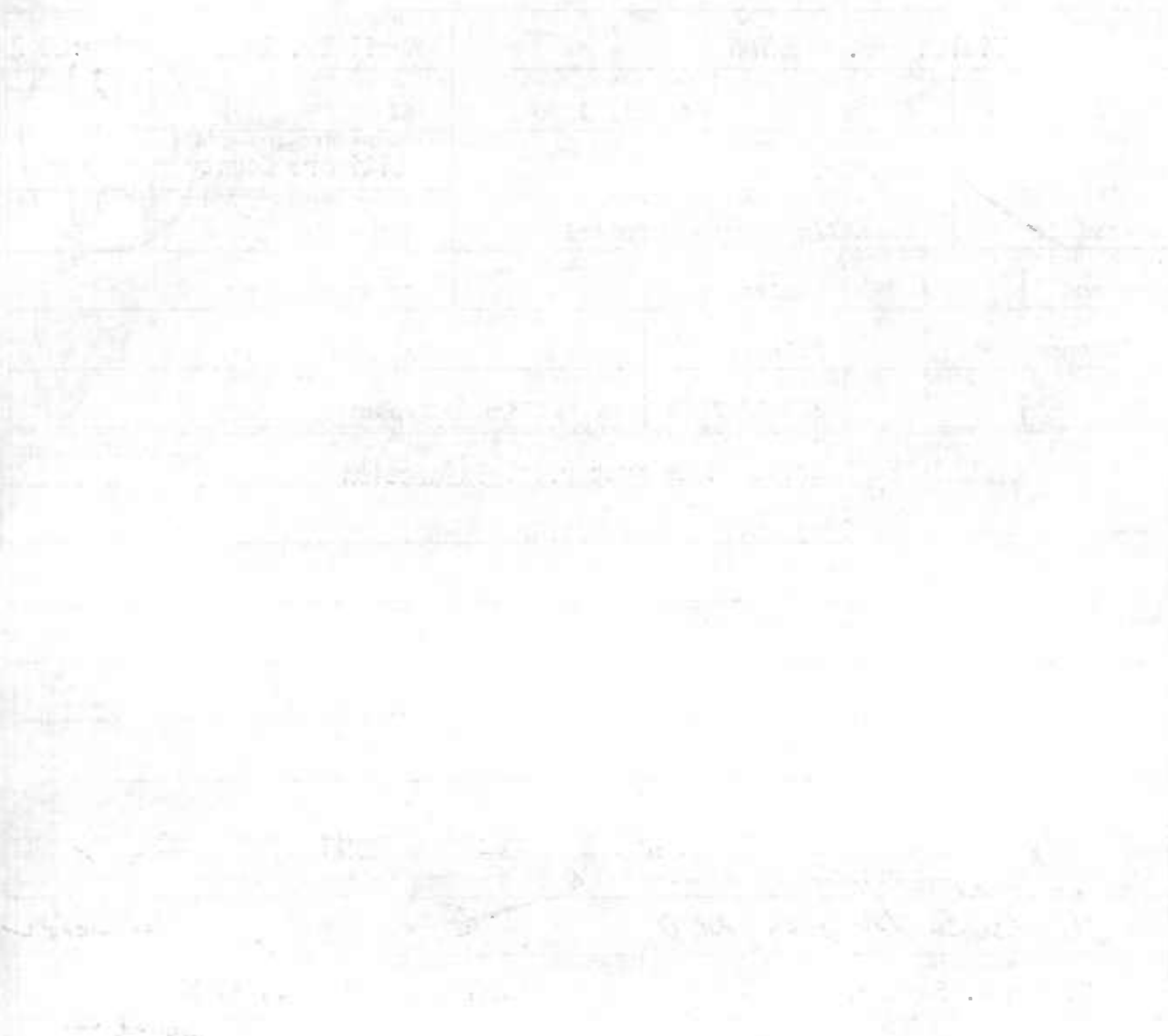
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |                                  |   |   |  |                                   | 8 2 0 8 5 3 7<br>REG. NO.                    |              |                  |  |      |           |  |
|--|--|--|--|--|----------------------------------|---|---|--|-----------------------------------|--|--------------|------------------|--|------|-----------|--|
| 1. FOR STATE REGISTRAR   |  |  |  |  | 1. DECEASED NAME (TYPE OR PRINT) |   |   |  |                                   | 2a. DATE OF DEATH                            |              |                  |  |      | 2b. HOUR  |  |
|  |  |  |  |  | Violet P. BRYAN                  |   |   |  |                                   | April 20, 1982                               |              |                  |  |      | 3:20 P.M. |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |                                  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |   | IF UNDER 1 YEAR  |                                   | IF UNDER 24 HRS.                             |              |                  |  |      |           |  |
| Female   |  | White  |  | Dec 31, 1920   |                                  | 61  |   | MONTHS   |                                   | DAYS   |              | HOURS            |  | MIN. |           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |   |  |                                   |  |              |                  |  |      |           |  |
| Maryland   |  | U.S.A.   |  |  |                                  | Baltimore County  |   |  |                                   |  | MD.          |                  |  |      |           |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |                                  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |              |                  |  |      |           |  |
| Rossville  |  | Franklin Square Hospital   |  |  |                                  |   | Housewife   |  |                                   |  |              |                  |  |      |           |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |                                  | 13d. INSIDE CITY LIMITS?  |   | 13e. STREET ADDRESS  |                                   |  |              |                  |  |      |           |  |
| Maryland   |  | Baltimore  |  | Baltimore  |                                  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 432 Elmwood Rd   |                                   |  |              |                  |  |      |           |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  |  |                                  |   |   |  |                                   |  |              |                  |  |      |           |  |
| Clarence   |  | Hiltner  |  | Unknown  |                                  |   |   |  |                                   |  |              |                  |  |      |           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |                                  | ADDRESS   |   |  |                                   |  |              |                  |  |      |           |  |
| No   |  | 212-18-7653  |  | Mr William C Bryan   |                                  | Same  |   |  |                                   |  |              |                  |  |      |           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:  |  |  |  |  |                                  |   |   |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |              |                  |  |      |           |  |
| IMMEDIATE CAUSE (a) Massive Acute Myocardial Infarction  |  |  |  |  |                                  |   |   |  |                                   |  |              |                  |  |      |           |  |
| 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |  |  |                                  |   |   |  |                                   |  |              |                  |  |      |           |  |
| (b) Congestive Heart Failure   |  |  |  |  |                                  |   |   |  |                                   |  |              |                  |  |      |           |  |
| (c)  |  |  |  |  |                                  |   |   |  |                                   |  |              |                  |  |      |           |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  |  |  |  |  |                                  |   |   |  |                                   |  |              |                  |  |      |           |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |                                  | 20a. AUTOPSY?   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                                   |  |              |                  |  |      |           |  |
|  |  |  |  |  |                                  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                                   |  |              |                  |  |      |           |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |                                  |   |   |  |                                   |  |              |                  |  |      |           |  |
|  |  | HOUR A.M. MONTH DAY YEAR   |  |  |                                  |   |   |  |                                   |  |              |                  |  |      |           |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION  |                                  |   |   |  |                                   |  |              |                  |  |      |           |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  | STREET   |                                  | CITY OR TOWN  |   |  |                                   |  | COUNTY STATE |                  |  |      |           |  |
| 22a. I certify that (this hospital) attended the deceased from April 10, 1982, to April 20, 1982, that (we) last saw the deceased alive on April 20, 1982 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |                                  |   |   |  |                                   |  |              |                  |  |      |           |  |
| 22b. SIGNATURE   |  |  |  |  |                                  |   |   |  |                                   | DEGREE                                       |              | 22c. DATE SIGNED |  |      |           |  |
| Steven B. Snyder, M.D.   |  |  |  |  |                                  |   |   |  |                                   |  |              | 4/20/82          |  |      |           |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  |  |                                  |   |   |  |                                   | 22e. ADDRESS                                 |              |                  |  |      |           |  |
| Steven B. Snyder, MD   |  |  |  |  |                                  |   |   |  |                                   | 9000 Franklin Square Dr., 21237              |              |                  |  |      |           |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |                                  | 23d. LOCATION   |   |  |                                   |  |              |                  |  |      |           |  |
| Burial   |  | 4/24/82  |  | Gardens Of Faith   |                                  | Baltimore, Maryland   |   |  |                                   |  |              |                  |  |      |           |  |
| 24. FUNERAL DIRECTOR   |  |  |  |  |                                  |   |   |  |                                   | 25a. DATE REC'D. BY REGISTRAR                |              |                  |  |      |           |  |
| Leonard J Ruck Inc. Baltimore, Maryland  |  |  |  |  |                                  |   |   |  |                                   | APR 22 1982                                  |              |                  |  |      |           |  |

1-6-32 28

STANDARD GRADE  
STANDARD GRADE  
STANDARD GRADE



John P. Jones  
SS 1965

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |  |  | 8 2 0 8 5 3 8  |  |                                |  |              |  |                    |  |
|--|--|---|--|---|--|--|--|--|--|--|--|--------------------------------|--|--------------|--|--------------------|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | 2. DECEASED NAME<br>(TYPE OR PRINT)   |  |   |  |  |  |  |  | 20. DATE OF DEATH  |  |                                |  | 2b. HOUR     |  |                    |  |
|  |  | FIRST<br>JOHN   |  | MIDDLE<br>C.  |  | LAST<br>BUCHWALD, Jr.  |  |  |  | MONTH<br>4   |  | DAY<br>8                       |  | YEAR<br>1982 |  | 6:45A <sub>M</sub> |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12-24-25  |  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>56  |  | 7. UNDER 1 YEAR<br>MONTHS DAYS   |  | 8. UNDER 24 HRS.<br>HOURS MIN. |  |              |  |                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.   |  |  |  |                                |  |              |  |                    |  |
| 10. CITY OR TOWN OF DEATH<br>TOWSON  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>GBMC-6701 N. CHARLES ST. |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>CONTRACTOR |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>SELF EMPLOYED   |  |                                |  |              |  |                    |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MD.  |  |   |  | 13b. COUNTY<br>BALTO.   |  | 13c. CITY OR TOWN<br>BALTO.  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS<br>2535 HILLCREST AVE.   |  |                                |  |              |  |                    |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>JOHN C. BUCHWALD, SR.  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>PHILENA H. HORN  |  |  |  |  |  |  |  |                                |  |              |  |                    |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>YES.   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>W.W.II   |  | 16c. SOCIAL SECURITY NO.<br>212-20-9598   |  | 17. INFORMANT<br>Mrs. Jacquelyn C. Buchwald - 2535 Hillcrest Ave               |  |  |  |  |  |                                |  |              |  |                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>METASTATIC CARCINOMA OF THE LUNG</u><br>1629<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |                                |  |              |  |                    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____  |  |   |  |   |  |  |  |  |  |  |  |                                |  |              |  |                    |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                |  |              |  |                    |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |  |                                |  |              |  |                    |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |                                |  |              |  |                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4-04</u> , 19 <u>82</u> , to <u>4-08</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>4-08</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.               |  |   |  |   |  |  |  |  |  |  |  |                                |  |              |  |                    |  |
| 22b. SIGNATURE<br>Samuel Jacobs MD   |  |   |  | DEGREE  |  |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>4/8/82   |  |                                |  |              |  |                    |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Samuel L. Jacobs MD   |  |   |  | 22e. ADDRESS<br>GBMC  |  |  |  |  |  |  |  |                                |  |              |  |                    |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  |   |  | 23b. DATE<br>4-10-82  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>CRESTLAWN CEM.                           |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO. MD.   |  |                                |  |              |  |                    |  |
| 24. FUNERAL DIRECTOR<br>Faith Green - 7527   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>APR 12 1982  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br>Francis J. K... ..   |  |  |  |                                |  |              |  |                    |  |

*[Faint, illegible text from bleed-through]*



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 5 3 9

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |   |  |  |
|--|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>John C BURNETT  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>April 25, 1982   |  | 2b. HOUR<br>5:40PM   |
| 3. SEX<br>M  | 4. RACE<br>W   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>2/16/20   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>62 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>ARK   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County, MD.                                   |  |  |
| 10. CITY OR TOWN OF DEATH<br>ROSSVILLE   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>FRANKLIN SQ |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>UNDER COATING               |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br>MD.  | 13b. COUNTY<br>BALTO   | 13c. CITY OR TOWN<br>DUNPARK  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br>7846 KAVANAUGH RD   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>OLLIE BURNETT  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>JOHNIE UNK   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>YES  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>ILW II   | 17. INFORMANT<br>ADDRESS<br>WELLIE BURNETT ABOVE  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u><br>2866<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Sepsis, Meningitis, Meningothelial Meningioma</u><br>(c) <u>Possible Disseminated Intravascular Coagulopathy</u> |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (X) (this hospital) attended the deceased from January 3, 1982, to April 25, 1982, that (X) (we) lost saw the deceased alive on April 25, 1982, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above (X) (we) (did) (did not) view the body after death.   |  |   |   |  |  |
| 22b. SIGNATURE<br>Shyuan Huang   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |   | 22c. DATE SIGNED<br>4/25/82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Shyuan Huang, M.D.  |  | 22e. ADDRESS<br>9000 Franklin Square Drive 21237  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>REMOVAL  | 23b. DATE<br>4/27/82   | 23c. NAME OF CEMETERY OR CREMATORY<br>CROSSETT  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>CROSSETT ARK.                          |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>J.G. CONNELLY  |  | ADDRESS<br>300 MACE   |   | 25a. DATE REC'D. BY REGISTRAR<br>APR 28 1982   | 25b. REGISTRAR'S SIGNATURE   |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                  |  |  |  |   |  |  |  | 2  | 0  | 8  | 5   | 4   | 0 |  |  |
|--|--|------------------|--|--|--|---|--|--|--|--|--|--|---|---|---|--|--|
| 1- FOR STATE REGISTRAR   |  |                  |  |  |  |   |  |  |  | REG. NO.   |  |  |   |   |   |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>Mardee Burton   |  |                  |  |  |  |   |  |  |  | 2b. DATE KNOWN OF DEATH<br>ESTIMATED MONTH DAY YEAR<br>4 11 1982         |  |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>4 11 1982 |   |   |  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>Black |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10 18 1909   |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY YRS.<br>72           |  | IF UNDER 1 YR.<br>MONTHS DAYS  |  | IF UNDER 24 HRS.<br>HOURS MIN.   |  | 2d. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>4 11 1982                  |   |   |   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  |                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.   |  |   |  | 8. MARRIED<br>WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD              |  |  |   |   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Catonsville   |  |                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>208 Winters Lane |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Chauffeur   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Pvt. Family |  |   |   |   |  |  |
| 13a. STATE<br>Maryland   |  |                  |  |  |  |   |  |  |  | 13b. COUNTY<br>BALTO   |  | 13c. CITY OR TOWN<br>Catonsville   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS<br>208 Winters Lane<br>Catonsville, Maryland 21228 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Gus Burton   |  |                  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Elizabeth Bennett |   |  |  |  | 16. SOCIAL SECURITY NO.<br>220-03-6370                                   |  |  |   |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No  |  |                  |  |  | 16b. SOCIAL SECURITY NO.<br>220-03-6370                            |   |  |  |  | 17. INFORMANT<br>Mr. Theodore Burton 302 Winters Lane                    |  |  |   |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>4292 IMMEDIATE CAUSE (a) <u>ASVD</u><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last<br>(b)<br>(c)<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>years</u>   |  |                  |  |  |  |   |  |  |  |  |  |  |   |   |   |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |  |                  |  |  |  |   |  |  |  |  |  |  |   |   |   |  |  |
| 19a. DATE OF OPERATION   |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |  |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |   |   |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |  |  |  |  |   |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |   |   |   |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                  |  |  |  |   |  |  |  |  |  |  |   |   |   |  |  |
| ACTUAL SIGNATURE<br><i>E. P. Williamson II</i>   |  |                  |  | TITLE (SPECIFY)<br>M.D. <i>Deputy</i>  |  |   |  | MEDICAL EXAMINER   |  |  |  | DATE SIGNED<br>4/11/82   |   |   |   |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>E. P. Williamson II  |  |                  |  | ADDRESS<br>5550 BALTO NAT'L PK 21228   |  |   |  |  |  |  |  |  |   |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |                  |  | 23b. DATE<br>4/16/82   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Arbutus Mem. Park |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore County, Maryland |  |  |   |   |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>HERBERT E. NUTTER  |  |                  |  | ADDRESS<br>BALTIMORE MARYLAND 21216  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>APR 13 1982   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Frances Jan Thorton</i>                 |   |   |   |  |  |

0 1 8 0 - 0

1712 1985  
James J. Johnston

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |  |  | 8 2 0 8 5 4 1   |  |
|--|--|--|--|---|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO.   |  |   |  |  |  |  |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST L. MIDDLE LAST<br><b>OLIVE BURTON</b>  |  |   |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4/22/82</b>  |  | 2b. HOUR<br><b>4:10 PM</b>                                    |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>April 27, 1890</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>92</b> YRS   |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS<br>HOURS MIN.                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE County MD.</b>                      |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>6701 N CHARLES ST GBMC</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK OR MOST OF WORKING LIFE)<br><b>School Teacher</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Education</b>  |  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE COUNTY CITY OR TOWN<br><b>Maryland Balto. Monkton</b>  |  | 13b. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13c. STREET ADDRESS<br><b>17000 York Road</b>   |  |  |  |  |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Lloyd</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Laura Bull</b>   |  |   |  |  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>215-32-9965</b>   |  | 17. INFORMANT ADDRESS<br><b>Harold F. Burton, Timonium, Md.</b>   |  |  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CEREBROVASCULAR ACCIDENT</b><br><b>4292</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <b>ASCVD, DEEP VEIN THROMBOPHLEBITIS</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(c) <b>MALIGNANCY, ? ETIOLOGY</b> |  |  |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 wks.</b> |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |  |  |   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>     |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>APRIL 14, 1982</b> to <b>APRIL 22, 1982</b> , that (I) (we) lost saw the deceased alive on <b>APRIL 22, 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Ruth Kantor MD</b>  |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  |  |  | 22c. DATE SIGNED<br><b>4/22/82</b>   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR RUTH KANTOR</b>   |  |  |  | 22e. ADDRESS<br><b>GBMC</b>   |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>4-25-1982</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Hereford Baptist</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Hereford, Balto., Md.</b>               |  |  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>JJ Horstenstein, Second St. New Freedom, Pa</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 3 1982</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |  |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
 STATE  
 REGISTRAR

STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

8 2 0 8 5 4 2

REG. NO.

|  |  |   |   |   |   |   |  |  |
|--|--|---|---|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>ANNE C. BUSCHMAN</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4/27/82</b>   |   |   | 2b. HOUR<br><b>1:30 P.M.</b>                          |  |  |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Nov. 1st, 1906</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b>  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>YRS.</b>         |  | IF UNDER 24 HRS.<br>HOURS MIN.<br><b>MD.</b> |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Baltimore, Md.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b>                         |   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>GBMC-6701 N. Charles St.</b> |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Clerk-Typist</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Insurance</b> |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Md.</b> 13b. COUNTY <b>BALTO.</b> 13c. CITY OR TOWN <b>Balto. City</b> |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>604 Nicoll Avenue-21212</b> |   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>David Bryan</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>(1) Fischer</b>                             |   |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>no</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>212-10-3275</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>Mr. Stephen J. Buschman-604 Nicoll Ave 12</b>            |   |   |  |  |

|   |  |   |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio Pulmonary Arrest</b>  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| 4280<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause last.<br>} DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Congestive Heart Failure</b><br>} DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |

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| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |  |   |
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)        |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4/31</b> 19 <b>82</b> , to <b>4/27/</b> 19 <b>82</b> , that (I) (we) last<br>saw the deceased alive on <b>4/27/</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |   |
| 22b. SIGNATURE<br><i>Eliza Brown</i>   |  | 22c. DATE SIGNED<br><b>4/30/82</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Eliza Brown, M.D.</b>  |  | 22e. ADDRESS<br><b>GBMC-6701 N. Charles St.</b>                                      |   |

|   |                             |   |  |
|---|-----------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>  | 23b. DATE<br><b>4/30/82</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>DULANEY VALLEY</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO. C. BALTO. C. MD.</b> |
| 24. FUNERAL DIRECTOR<br><b>MITCHELL NIEDEFELO</b> |                             | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 3 1982</b>          |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DHMH - 16 50M 1/81  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |  |   |   |  |  |   | 8 2 0 8 5 4 3  | D.S.T.  |   |  |
|--|--|--|---|--|---|---|--|--|---|--|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>AUDREY E. BUTZ</b>  |  |  |   |  |   |   |  |  |   | REG. NO.   |   | D.S.T.  |  |
| 2a. DATE OF DEATH MONTH DAY YEAR<br><b>04 24 82</b>  |  |  | 2b. HOUR<br><b>11:40A</b>   |  | 3. SEX<br><b>FEMALE</b>   |   |  | 4. RACE<br><b>WHITE</b>  |   | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>05 19 23</b>         |   | 6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS HOURS MIN.<br><b>58</b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY MD.</b>   |  |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>ARBUTUS</b>  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1247 ELM ROAD, 21227</b> |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SECRETARY</b>   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>HOSPITAL</b>  |  |   |   |  |
| 13a. STATE<br><b>MARYLAND</b>  |  |  | 13b. COUNTY<br><b>BALTIMORE</b>   |  | 13c. CITY OR TOWN<br><b>ARBUTUS</b>                               |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>1247 ELM ROAD, 21227</b>  |  |   |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>RAYMOND M. WILSON</b>  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>AUGUSTA STEINITZ</b>   |  |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>  |  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br><b>217-12-0294</b>  |  | 17. INFORMANT ADDRESS<br><b>JOHN H. BUTZ 1247 ELM ROAD, 21227</b> |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Renovascular disease &amp; failure</b><br><b>2500</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Diabetes mellitus</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |  |   |  |   |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>yes</b> |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Arteriosclerotic Cardiovascular &amp; Cerebrovascular disease</b>  |  |  |   |  |   |   |  |  |   |  |   |   |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>19</b>   |  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |   |  |   |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |   |  |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6</b> , 19 <b>76</b> , to <b>4</b> , 19 <b>82</b> , that (we) last saw the deceased alive on <b>4-24</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                     |  |  |   |  |   |   |  |  |   |  |   |   |  |
| 23a. SIGNATURE <b>Laurence R. Gallager, M.D.</b> DEGREE  |  |  |   |  |   |   |  |  |   | 23b. DATE SIGNED<br><b>4-26-82</b>                         |   |   |  |
| 23c. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>LAURENCE R. GALLAGER, M.D.</b>   |  |  |   |  |   |   |  |  |   | 23d. ADDRESS<br><b>ST. AGNES MEDICAL CENTER</b>            |   |   |  |
| 23e. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  |  | 23f. DATE<br><b>04-28-82</b>  |  | 23g. NAME OF CEMETERY OR CREMATORY<br><b>MEADOWRIDGE MEM. PD.</b> |   |  | 23h. LOCATION CITY OR TOWN COUNTY STATE<br><b>ELKRIDGE HOWARD MARYLAND</b> |   |  |   |   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>HUBBARD FUNERAL HOME, INC.</b>   |  |  |   |  |   | 24b. ADDRESS<br><b>21229 4107 WILKENS AVE.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 26 1982</b>                        |   | 25b. REGISTRAR'S SIGNATURE<br><i>James J. [Signature]</i>  |   |   |  |

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Item #17 Film G566 4/26/82 rc

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 5 4 4

1- STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |   |  |
|--|--|---|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Alta C. Cain  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>April 17 1982 |   | 2b. HOUR<br>8:10 <sup>3</sup> M   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Aug. 6 1911   |   | 6. AGE (IN YEARS (LAST BIRTHDAY))<br>70 YRS  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.   |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>3806 Edgewater Place |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker |  |
| 13a. STATE<br>Md.  |  | 13b. COUNTY<br>Balto.   |  | 13c. CITY OR TOWN<br>Baltimore  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Alonzo Steinert  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Catherine Hoffmann   |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>214-18-1947  |  | 17. INFORMANT<br>ADDRESS<br>3921 Putty Hill Ave.<br>Bruce Cain (son) same address 21236   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Myocardial Infarction<br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Arteriosclerotic Cardiovascular Disease<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>hours |  |   |  |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>Chronic obstructive and Restrictive Pulmonary disease   |  |   |  |   |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death.                |  |   |  |   |   |  |
| 22b. SIGNATURE<br>Dr. Salvatore Donohue  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |   | 22c. DATE SIGNED   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Salvatore Donohue   |  |   |  | 22e. ADDRESS<br>Maryland General Hospital   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>4/21/82  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Gardens of Faith  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. Md.   |
| 24. FUNERAL HOME<br>Schlimmek Funeral Home, Inc.<br>3331 Brehms Lane, Balto. Md. 21213   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>APR 20 1982  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |   |  |  |  |               | 8 2 0 8 5 4 5   |  |  |  |
|---|--|--|--|---|---|--|--|--|---------------|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  |   |   |  |  |  |               | REG. NO.  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>GRACE R. CAREY</b>  |  |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>April 27, 1982</b> |  |  |  | 2b. HOUR<br>M |   |  |  |  |
| 3 SEX<br><b>Female</b>  |  | 4 RACE<br><b>White</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Jan. 6, 1889</b>  |   | 6 AGE (IN YEARS LAST BIRTHDAY) YRS.<br><b>93</b>   |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |               |   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County, MD.</b>                         |  |  |               |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Manor Care-Ruxton</b> |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>   |               |   |  |  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>21204</b>   |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>103 Alleghany Avenue</b>   |               |   |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>John Thomas Ridgely</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Sarah Jervis</b>   |   |  |  |  |               |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br><b>-----</b>   |  | 17. INFORMANT ADDRESS<br><b>Ann C. Heintzelman Balto., MD 21234</b>   |   |  |  |  |               |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:<br><b>4292</b> IMMEDIATE CAUSE (a) <b>Cardiac Failure</b>   |  |  |  |   |   |  |  |  |               | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Arterioschrotic Cardio Vascular Disease 10 yrs.</b>  |  |  |  |   |   |  |  |  |               |   |  |  |  |
| (c)   |  |  |  |   |   |  |  |  |               |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |   |  |  |  |               |   |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |               | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)               |  |  |               |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |               |   |  |  |  |
| 22a. I certify that (I) (the funeral director) attended the deceased from <b>1 Sept. 74</b> to <b>27 April 82</b> , that (I) <b>XX</b> saw the deceased alive on <b>27 April 82</b> , and that in (my) <b>XX</b> opinion death occurred on the date and hour and from the causes stated above. (I) <b>XXXX</b> did not view the body after death. |  |  |  |   |   |  |  |  |               |   |  |  |  |
| 22b. SIGNATURE <b>Walter T. Kees</b>  |  |  |  |   |   | DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |               | 22c. DATE SIGNED  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Walter T. Kees, M.D.</b>  |  |  |  |   |   | 22e. ADDRESS<br><b>Houcks Mill Road 557-7808</b>   |  |  |               |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |  |  | 23b. DATE<br><b>April 29, '82</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Bowling Green Farm</b>                              |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Sykesville, MD</b>   |               |   |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>William E. Johnson</b>  |  |  |  |   |   | ADDRESS<br><b>8521 Loch Raven Blvd.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 28 1982</b>  |               | 25b. REGISTRAR'S SIGNATURE<br><b>James J. Martin</b>  |  |  |  |

1. Name of the person or organization to whom the letter is addressed  
2. Address of the person or organization to whom the letter is addressed  
3. City, State, and Zip Code of the person or organization to whom the letter is addressed

4. Date of the letter  
5. Subject of the letter  
6. Salutation (e.g., Dear Sir, Dear Madam, Dear Mr. Smith)

7. Body of the letter (the main text of the letter)  
8. Closing (e.g., Sincerely, Very truly yours, Respectfully)

9. Signature of the person or organization sending the letter  
10. Name and Title of the person or organization sending the letter

11. Enclosures (if any)  
12. Postage (if any)

13. Return address (if any)  
14. Other information (if any)

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 5 4 6

REG. NO.

|  |  |  |   |  |  |
|--|--|--|---|--|--|
| 1. FOR STATE REGISTRAR   |  | 2a. DATE OF DEATH  |   | 2b. HOUR   |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | 2a. DATE OF DEATH  |   | 2b. HOUR   |  |
| LIZA A. CARLOCK.   |  | 04 11 82   |   | 10-12AM  |  |
| 3. SEX   | 4. RACE  | 5. DATE OF BIRTH   | 6. AGE (IN YEARS LAST BIRTHDAY)                               | IF UNDER 1 YEAR  |  |
| FEMALE   | CAUCASION.   | 05 06 47   | 34 YRS  | MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                          |  |  |
| Michigan   | U.S.A.   |  | Baltimore County MD.  |  |  |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  |  |
| Randallstown   | Baltimore County General Hospital  |  | Unemployed  |  |  |
| 13a. STATE   |  | 13b. COUNTY  | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| Maryland   | Baltimore  | Woodlawn   | 13e. STREET ADDRESS   |  |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |   | 16. SOCIAL SECURITY NO.  |  |
| Louis LaRose   |  | Nancy Bloom  |   | 378-50-2081  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT  |  |
| No   |  | 378-50-2081  |   | Mr. Russell Brown  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). 5712      |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). 5712                          |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| DUE TO, OR AS A CONSEQUENCE OF (b). ALCOHOLIC CIRRHOSIS  |  | DUE TO, OR AS A CONSEQUENCE OF (c).  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)       |   | 21b. TIME OF INJURY  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  | 21d. INJURY OCCURRED   |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                          |  |
| 21f. LOCATION  |  | 21g. CITY OR TOWN  |   | 21h. COUNTY  |  |
| 21i. STATE   |  | 21j. STREET  |   | 21k. CITY OR TOWN  |  |
| 21l. COUNTY  |  | 21m. STATE   |   | 21n. CITY OR TOWN  |  |
| 21o. STREET  |  | 21p. CITY OR TOWN  |   | 21q. COUNTY  |  |
| 21r. STATE   |  | 21s. CITY OR TOWN  |   | 21t. COUNTY  |  |
| 21u. STREET  |  | 21v. CITY OR TOWN  |   | 21w. COUNTY  |  |
| 21x. STATE   |  | 21y. CITY OR TOWN  |   | 21z. COUNTY  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 3-30-1982 to 4-11-1982, that (I) (we) lost                        |  | 22b. SIGNATURE   |   | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |   | 22f. CITY OR TOWN  |  |
| DR. SUDHIR D. PATEL.   |  | Bal. County Gen. Hosp.   |   | 4-11-82  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY   |  |
| Cremation  |  | 4-13-82  |   | Westview Crematory   |  |
| 23d. LOCATION  |  | 23e. CITY OR TOWN  |   | 23f. COUNTY  |  |
| Catonsville  |  | Balto.   |   | Maryland   |  |
| 24. FUNERAL DIRECTOR   |  | 24. DATE REC'D. BY REGISTRAR   |   | 24. REGISTRAR'S SIGNATURE  |  |
| Loring Byers Funeral Directors, Inc.   |  | APR 13 1982  |   | James J. Nathan  |  |
| 8728 Liberty Road  |  | Randallstown, MD. 21133  |   |  |  |

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |  |  | 8 2 0 8 5 4 7<br>REG. NO.   |  |                                   |  |          |  |         |  |
|---|--|---|--|---|--|---|--|--|--|---|--|-----------------------------------|--|----------|--|---------|--|
| 1. FOR STATE REGISTRAR  |  |   |  |   |  |   |  |  |  | 2a. DATE OF DEATH   |  |                                   |  | 2b. HOUR |  |         |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Emma L Carlos  |  |   |  |   |  |   |  |  |  | 4   |  | 22                                |  | 82       |  | 3:20 PM |  |
| 3. SEX<br>Female  |  | 4. RACE<br>Black  |  | 5. DATE OF BIRTH<br>9 MONTH 1 DAY 97 YEAR   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>84 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |   |  |                                   |  |          |  |         |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>S.C.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                    |  |  |  |   |  |                                   |  |          |  |         |  |
| 10. CITY OR TOWN OF DEATH<br>Towson   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Greater Baltimore Medical Center |  |   |  |   |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |          |  |         |  |
| 13a. STATE<br>MD  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>1236 E. Lafayette Ave.  |  |   |  |                                   |  |          |  |         |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Aaron Montgomery  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Lue Allen  |  |   |  |  |  |   |  |                                   |  |          |  |         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>212-74-3154   |  | 17. INFORMANT ADDRESS<br>Ollie Carlos 1236 E. Lafayette Ave.  |  |   |  |  |  |   |  |                                   |  |          |  |         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardio-respiratory arrest</u><br>4/00<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Myocardial Infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) |  |   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |                                   |  |          |  |         |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |                                   |  |          |  |         |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |   |  |                                   |  |          |  |         |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |   |  |                                   |  |          |  |         |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/22</u> , 19 <u>82</u> , to <u>4/22</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>4/22</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |  |  |  | 22b. SIGNATURE<br><u>Cheleleiber MD</u><br>DEGREE<br>MD<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>4-23-82       |  |          |  |         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>V. V. CHELELEIBER MD   |  |   |  | 22e. ADDRESS<br>GBMC  |  |   |  |  |  |   |  |                                   |  |          |  |         |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>4/27/82  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore Cem   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore MD                                      |  |  |  |   |  |                                   |  |          |  |         |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H  |  |   |  | ADDRESS<br>1101 E. North Ave.   |  | 25. RECEIVED BY REGISTRAR<br>APR 23 1982 REGISTRAR'S SIGNATURE                                  |  |  |  |   |  |                                   |  |          |  |         |  |

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RECEIVED  
U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C. 20250

4-10-82 23 1982

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |   |  | 8 2 0 8 5 4 8                                |  |
|---|--|---|--|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  | REG. NO.  |  |   |  |   |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Irene Allen Casper</b>  |  |   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 9, 1982</b>                                     |  |   | 2b. HOUR<br><b>8 AM</b>  |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>April 14, 1919</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>62</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>0 0</b>                                |  | IF UNDER 24 HRS.<br>HOURS MIN.<br><b>0 0</b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New Haven, Conn.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County MD.</b>                             |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Dundalk</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>5 Admiral Blvd.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>            |  |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Balto.</b>  |  | 13c. CITY OR TOWN<br><b>Dundalk</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>5 Admiral Blvd. 21222</b>                         |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John L. XX Staley</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Irene Allen</b>   |  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>218.05.4573</b>   |  | 17. INFORMANT ADDRESS<br><b>Arthur Casper (Husband) (Same as 13e)</b>   |  |   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Alzheimer's Disease -</u><br><b>3310</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |  |   |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>4/9 1982</b>     |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |  |   |  |  |  |
| 22a. I certify that (I) <u>this hospital</u> attended the deceased from <u>3</u> 19 <u>82</u> to <u>4/9</u> 19 <u>82</u> , that <del>the</del> (we) last saw the deceased alive on <u>4/8</u> 19 <u>82</u> , and that in (my) <u>last</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>did</u> (did not) view the body after death. |  |   |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><u>James P. Keogh M.D.</u>  |  |   |  |   |  | DEGREE<br><b>MD</b>   |  |   | 22c. DATE SIGNED<br><u>4/9/82</u>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JAMES P. KEOGH M.D.</b>   |  |   |  |   |  | 22e. ADDRESS<br><b>6216 EASTERN AVE BALTO 21224</b>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |   | 23b. DATE<br><b>4/12/1982</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Sacred Heart Cemetery</b>             |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Dundalk Balto Maryland</b> |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Walter Brooks Bradley Inc., Dundalk Md 21222</b>   |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 15 1982</b>   |  |   |  |  |  |

3 4 5 8 0

582 57 996

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |   |  |  |  |  | 8 2 0 8 5 4 9                                |  |  |  |
|--|--|---|--|---|---|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  |   |   |  |  |  |  | REG. NO.                                     |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>PAUL HERBERT CAVE</b>   |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4-25-82</b>   |  |  |  |  | 2b. HOUR<br><b>5:45 P.M.</b>                 |  |  |  |
| 3. SEX<br><b>M</b>   |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7-7-06</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b> YRS.  |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.              |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>WEST VIRGINIA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO. Co.; BALTO., MD.</b>                       |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>HERITAGE NURSING CENTER</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>CLERK TIME KEEPER</b> |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>STEEL MFR.</b> |  |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MARYLAND</b> 13b. COUNTY <b>BALTIMORE</b> 13c. CITY OR TOWN <b>DUNDALK</b>  |  |   |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>2905 DUNHURRY RD #B 21222</b>                |  |  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ISAAC NEWTON CAVE</b>   |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>DAISY SULLIVAN</b>                          |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WW II 213-07-289</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>MRS. CAVE 2905 DUNHURRY RD #B 2847045</b>  |   |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pneumonia</b><br><b>4860</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>Detonating Isotatic Carcinoma</b>   |  |   |  |   |   |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>         |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                      |  |   |  |   |   |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Michael J. Fawcett MD</b>   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |   |  |  | 22c. DATE SIGNED<br><b>4/26/82</b>   |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |   |  | 22e. ADDRESS  |   |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>   |  | 23b. DATE<br><b>4/28/1982</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MEADOWRIDGE MEM. PK.</b>   |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ELKRIDGE MARYLAND</b> |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>WALTER BROOKS BRADLEY INC. DUNDALK MD 21222</b>   |  |   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 29 1982</b>  |  |  |  |  |  |  |  |
|  |  |   |  |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>James J. Nathan</b>   |  |  |  |  |  |  |  |

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UNITED STATES  
DEPARTMENT OF AGRICULTURE  
WASHINGTON, D. C.

DATE

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UNITED STATES

DEPARTMENT OF AGRICULTURE

WASHINGTON, D. C.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 5 5 0

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|   |  |  |  |   |  |  |   |  |   |   |  |
|---|--|--|--|---|--|--|---|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Mable A. CHAMBERS  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>April 14, 1982                  |   |  | 2b. HOUR<br>9:05 P <sub>M</sub>  |   |  |   |   |  |
| 3. SEX<br>F   |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>MAY 11 1905   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>76 YRS  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.   |   |  |   |   |  |
| 10. CITY OR TOWN OF DEATH<br>ROSSVILLE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>FRANKLIN SQUARE |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>SEAMSTRESS   |   | 12b. KIND OF BUSINESS OR INDUSTRY  |   |   |  |
| 13a. STATE<br>MD  |  |  | 13b. COUNTY<br>BALTO   |   | 13c. CITY OR TOWN<br>DUNDALK                       |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>3426 LOGANVIEW DR. |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Boyd METCALF  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>— — —                 |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) NO  |   |  |   | 16b. SOCIAL SECURITY NO.<br>800-02-1739 |  |
| 17. INFORMANT<br>DOUGLASS SCHERR  |  |  | ADDRESS<br>PO Box 344<br>GRASONVILLE MD.                               |   |  |  |   |  |   |   |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiopulmonary arrest due to upper<br>5789 gastrointestinal bleed<br>DUE TO, OR AS A CONSEQUENCE OF (b) —<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) —<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |   |  |  |   |  |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |   |  |  |   |  |   |   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |   |   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from February 12, 19 82, to April 14, 19 82, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 14, 19 82, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did not view the body after death.             |  |  |  |   |  |  |   |  |   |   |  |
| 22b. SIGNATURE<br>Richard D. Del Pero MD  |  |  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br>4/14/82  |   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Richard Del Pero MD  |  |  |  |   |  | 22e. ADDRESS<br>9000 Franklin Square Dr., 21237  |   |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  |  | 23b. DATE<br>APR. 17, 1982   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>MEADOW RIDGE |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>MD.   |  |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>CONNELLY FUNERAL HOME DUNDALK   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>APR 21 1982   |   | 25b. REGISTRAR'S SIGNATURE<br>James J. [Signature]   |   |   |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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FOR  
1 - STATE  
REGISTRAR

REG. NO.

|   |  |  |   |  |  |
|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>WINFIELD HAMILTON CHASE</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4/10/82 4 19 82</b>                                   |  | 2b. HOUR<br>MIN.<br><b>4 05 PM</b>   |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>NEGRO</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4 18 04</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b> YRS.                              | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>BALTO. MD.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO. COUNTY MD.</b>               |  |
| 10. CITY OR TOWN OF DEATH<br><b>CATONS, MD.</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>RIDGEWAY MANOR N. H.</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>CUSTODIAN</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br><b>MD.</b>  | 13b. COUNTY<br><b>BALTO.</b>   | 13c. CITY OR TOWN<br><b>BALTO.</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>3800 W. REVEDERE AVE 2215</b>                        |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Henry Chase</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Jennie Adams</b>   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.<br><b>217-01-9992A</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>AUDREY BOOKER 3307 BELLE AVE. 2215</b>          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>STROKE PNEUMONIA EDEMA.</b><br><b>4360</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>STROKE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1-7</b> , 19 <b>82</b> to <b>4/10</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>4/10</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                       |  |  |   |  |  |
| 22b. SIGNATURE<br><b>Norman R. Kleiman MD</b>   |  | DEGREE<br><b>MD</b>  |   | 22c. DATE SIGNED<br><b>4/10</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>NORMAN R. KLEIMAN MD</b>  |  | 22e. ADDRESS<br><b>3803 EDMONDSON AVE</b>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   | 23b. DATE<br><b>4/15/82</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Western Star Cem</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. MD.</b>                |  |
| 24. FUNERAL DIRECTOR<br><b>Lloyd D. Galt</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 12 1982</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>James J. Nathan</b>                           |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |  |  | 8 2 0 8 5 5 2                                |  |
|--|--|--|--|---|--|--|--|--|--|--|--|
| 1 - STATE REGISTRAR  |  |  |  |   |  |  |  |  |  | REG. NO.                                     |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Rose Rita CHISHOLM</b>   |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 16, 1982</b>   |  | 2b. HOUR<br>M<br><b>12:50 P</b>  |  |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>August 31, 1903</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rossville</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Square Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>   |  |  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Middle River</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>4 Gumwood Drive 21220</b>  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Frank Mrowcynski</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Frances Ekwert</b>  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>220 36 8823</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Rose F. Ashton Same</b>   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b><br><b>4280</b> DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Probable congestive heart disease decompensation</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c)   |  |  |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |  |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from <b>March 10</b> 19 <b>82</b> , to <b>April 16</b> 19 <b>82</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>April 16</b> 19 <b>82</b> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Steven B. Snyder M.D.</b>   |  |  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>4/16/82</b>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Steven B. Snyder, MD</b>   |  |  |  | 22e. ADDRESS<br><b>9000 Franklin Square Dr., 21237</b>  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>Burial</b>   |  | 23b. DATE<br><b>4-19-82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moreland Mem. Park</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>   |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Bruzdzinski Funeral Home PA</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 19 1982</b>   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Frances Jean Ashton</b>   |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and page 4 must be completed.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 5 5 3

REG. NO.

|  |  |  |  |   |  |  |  |  |  |
|--|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Ellen Richardson Clapp  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>4 25 82                         |   |  | 2b. HOUR<br>7:20 P M   |  |  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>7 2 97  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>84 YRS.   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Chicago, Illinois   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Cockeysville  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Broadmead |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>- - - -   |  |  |  |
| 13a. STATE<br>MD   |  | 13b. COUNTY<br>Balto.  |  | 13c. CITY OR TOWN<br>Cockeysville   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS<br>13801 York Road   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Charles F. Richardson  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Marsha Stevens   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>---   |  | 16c. SOCIAL SECURITY NO.<br>216-46-1885   |  | 17. INFORMANT<br>ADDRESS<br>Bldg.<br>Roger A. Clapp, 1700 1st Nat'l Bank   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>SEPSIS</u><br><u>4360</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>RECURRENT URINARY TRACT INFECTION</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>NEUROGENIC BLADDER</u> |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><u>S/P CEREBROVASCULAR ACCIDENT</u>  |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><u>Walker Lynn III MD</u>  |  |  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>4/26/82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  |   |  | 22e. ADDRESS   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation  |  |  | 23b. DATE<br>Apr. 27, 1982   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Westview Crematory |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Catonsville, Md. |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Lemmon-Mitchell-Wiedefeld, 10 W. Padonia Rd  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 3 1982  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Frances Jean Nathan</u>   |  |

0 8 1 2 2

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

TO : DIRECTOR, FBI  
FROM : SAC, NEW YORK  
SUBJECT: [Illegible]  
RE: [Illegible]

2/25/52

Re New York letter to Bureau dated 2/22/52.

Enclosed for the Bureau are two copies of a letterhead memorandum (LHM) dated and captioned as above.

The LHM is being furnished to the New York Office for its information.

2/25/52

Walter D. [Illegible]

Very truly yours,  
[Illegible Signature]  
Special Agent in Charge

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 5 5 4

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |   |   |                                |  |  |
|--|--|---|---|---|--------------------------------|--|--|
| DECEASED NAME<br>(TYPE OR PRINT)<br><b>LORENA Phillips Coates</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4/23/82</b> |   | 2b. HOUR<br>M<br><b>9:00 P</b> |  |  |
| 3. SEX<br><b>F</b>   |  | 4. RACE<br><b>W</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 28 43</b>  |                                | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS HOURS MIN.<br><b>58</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>ST. PAUL, MINN.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CO.</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>COCKEYSVILLE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BROADMEAD</b>   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK, FOR MOST OF WORKING LIFE)<br><b>SOCIAL WORKER</b>   |                                | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>DC</b>  |  | 13b. CITY OR TOWN<br><b>Washington</b>  |   | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                                | 13d. STREET ADDRESS<br><b>3205 33rd Place NW/DC</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>THOMAS A. PHILLEPS</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>LORENA HARRISON</b>   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |                                | 16b. SOCIAL SECURITY NO.<br><b>472-44-8627</b>   |  |
| 17. INFORMANT<br>ADDRESS<br><b>Mrs. Jane Fleming</b>   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Widespread Metastatic Carcinoma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |                                |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br><b>s/p @ hemispheric stroke.</b>   |  |   |   |   |                                |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                                |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                                |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4/15</b> , 19 <b>80</b> , to <b>4/23</b> , 19 <b>82</b> , that (I) (we) lost<br>saw the deceased alive on <b>4/23</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |   |   |                                |  |  |
| 22b. SIGNATURE<br><b>Robert Liberto, MD.</b>   |  |   |   | DEGREE<br><b>MD.</b>  |                                | 22c. DATE SIGNED<br><b>4/23/82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ROBERT LIBERTO, MD.</b>  |  |   |   | 22e. ADDRESS<br><b>3508 BANK ST. BALTO, 21224</b>   |                                |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>   |  | 23b. DATE<br><b>4/26/82</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Greenmount</b>   |                                | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore City, Maryland</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Mitchell-Wiedefeld Home, Inc. B lto., Md. 21212</b>   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 20 1982</b>   |                                | 25b. REGISTRAR'S SIGNATURE<br><b>James J. Harrison</b>   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 5 5 5

REG. NO.

|  |  |   |  |   |   |
|--|--|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Leona BARR COCHRAN</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 16, 1982</b>                         |   | 2b. HOUR<br><b>7:09 P</b>   |
| 3. SEX<br><b>FEMALE</b>  | 4. RACE<br><b>CAUCASIAN</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>01 19 28</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>54</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>VIRGINIA</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                             |   |
| 10. CITY OR TOWN OF DEATH<br><b>ROSSVILLE</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>FRANKLIN SQUARE HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>----</b>  |
| 13a. STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>----</b>  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>5908 GLEN FALLS AVE.</b>  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>----</b> <b>BARR</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>----</b>  |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>217201822</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>EDMUND LEDVINKA 19843 GORSMILL RD.</b>                           |   |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Brain injury</b><br><b>4960</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Chronic obstructive pulmonary disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)                  |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>April 10</b> , 19 <b>82</b> , to <b>April 16</b> , 19 <b>82</b> , that <input checked="" type="checkbox"/> (we) lost<br>saw the deceased alive on <b>April 16</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. |  |   |  |   |   |
| 22b. SIGNATURE<br><b>Ronald Orrell M.D.</b>  |  |   |  | 22c. DATE SIGNED<br><b>4/16/82</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Ronald Orrell M.D.</b>   |  |   |  | 22e. ADDRESS<br><b>9000 Franklin Square Dr., 21237</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>4/20/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>LOUDON PARK</b>  |   |
| 23d. LOCATION<br>CITY OR TOWN<br><b>BALTIMORE</b>  |  | COUNTY<br><b>----</b>   |  | STATE<br><b>MD.</b>   |   |
| 24. FUNERAL DIRECTOR<br><b>John Coach</b>  |  | ADDRESS<br><b>1211 Chesapeake Ave</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 19 1982</b>   |   |

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REAR

BUCKLE



LIBRARY

STANLEY SQUARE HOSPITAL

STANLEY

STANLEY SQUARE HOSPITAL

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STANLEY SQUARE HOSPITAL

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 5 5 6

REG. NO.

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>PAULINE Elizabeth COFIELD   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>4 3 1982   |  | 2b. HOUR<br>AM PM<br>11:00   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Dec 6 1926  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>55<br>YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>TOWSON  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>GBMC-6701 N. CHARLES ST. |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md.  |  |   |  | 13b. COUNTY<br>Balto.   |  | 13c. CITY OR TOWN<br>Cockeysville  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Seymour Bosley   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Laura Nellie Talbott               |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>---                      |  | 17. INFORMANT<br>ADDRESS<br>Timonium, Md.<br>Mrs. Dianna Kilgalen, 41 Evans Ave.  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARCINOMA OF THE STOMACH AND</b><br><b>1519</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>METASTASIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____ |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                    |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                          |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)              |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>3/23 82 4/3 82   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/3 82, to 4/3 82, that (I) (we) lost<br>saw the deceased alive on 4/3 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><i>S. P. Girdhar</i>   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br>4/3  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>S. P. GIRDHAR   |  |   |  | 22e. ADDRESS<br>GBMC 6701 N. CHARLES ST., TOWSON  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>4/8/82   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>St. Joseph's Ch. Cemetery   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Cockeysville, Md.  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Lemmon-Mitchell-Wiedefeld, 10 W. Padonia Rd.   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>APR 7 1982   |  |  |  |
|  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Frances Jean Whitham</i>   |  |  |  |

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OFFICE

THE CITY

GOVERNMENT

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 5 5 7

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|  |   |   |   |  |  |
|--|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Mary M. F. Cohen</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 9, 1982</b>                                     |  | 2b. HOUR<br><b>11:30 PM</b>  |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>March 7, 1982</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>91</b> YRS                                     | * IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Catonsville</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>413 Apt. F. Wheaton Pl.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>            | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>                                     |  |
| 13a. STATE<br><b>Maryland</b>  | 13b. COUNTY<br><b>Baltimore</b>   | 13c. CITY OR TOWN<br><b>Catonsville</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br><b>413 Apt. F. Wheaton Pl.</b>                                |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles Funk</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary (unknown)</b>  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>216-01-5864</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Jacqueline B. Eaton - Pasadena MD. 21122</b>          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <b>Extensor digitorum flexor digitorum</b><br><b>4140</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Pericardial Extension</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Myocardial</b> |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |   |   |   |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>7-15-82</b><br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7-15-82</b> 19, to <b>4-10-82</b> 19, that (I) (we) last saw the deceased alive on <b>4-7-82</b> 19, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |   |   |   |  |  |
| 22b. SIGNATURE<br><b>ARRY - S. GIMBEL</b>  |   | DEGREE  |   | 22c. DATE SIGNED<br><b>4-10-82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |   | 22e. ADDRESS<br><b>5200 South North Ave - 4109</b>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |   | 23b. DATE<br><b>April 13, 82</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge Cemetery</b>                               |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore MD.</b>   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Witzke Funeral Homes-Catonsville MD. 21228</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 12 1982</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>James J. [Signature]</b>                            |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination required.

Item 8 g567 5/6/82 gj

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 2 0 8 5 5 8  
CERTIFICATE OF DEATH

|   |  |   |   |   |
|---|--|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Eddie Colston  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>4 21 82  |   | 2b. HOUR<br>6:41A   |
| 3. SEX<br>Male  | 4. RACE<br>Black   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>April 28 1932   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>49                         |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Danville, Va.   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore, County MD. |
| 10. CITY OR TOWN OF DEATH<br>Towson   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>GBMC 6701 N. Charles Street |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Old   | 12b. KIND OF BUSINESS OR INDUSTRY                             |
| 13a. STATE<br>Maryland  | 13b. COUNTY<br>BALTO.  | 13c. CITY OR TOWN<br>Baltimore  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                               | 13e. STREET ADDRESS<br>4501 Pimlico Road                      |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Will Calston  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST  |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |   |
| 16b. SOCIAL SECURITY NO.<br>228-36-4390   |  | 17. INFORMANT<br>Helen Smith<br>2552 Locust, Wilmington, Del.   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u><br><u>1490</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Recurrent Cancer of Throat</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>with metastasis</u>  |  |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH               |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |   |   |
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>04/08</u> , 19 <u>82</u> , to <u>04/21</u> , 19 <u>82</u> , that (I) (we) lost<br>saw the deceased alive on <u>04/21</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |   |   |
| 22b. SIGNATURE<br>Jeffrey Greenspan   | DEGREE<br>M.D.   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  | 22c. DATE SIGNED<br>4/21/82   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Jeffrey Greenspan, M.D.  |  | 22e. ADDRESS<br>GBMC 6701 N. Charles Street   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  | 23b. DATE<br>4-2-82  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Zion Cemetery   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO. MD.  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>J. C. Brown   | ADDRESS<br>F. 46-1206-851 North  | 25a. DATE REC'D BY REGISTRAR<br>APR 26 1982   |   |   |

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Item 4 per phone 4/27/82 dad

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 5 5 9

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |   |   |   |   |   |  |  |  |
|--|--|---|---|---|---|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>LILLIAN CONN</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4 17 82</b>                   |   |   | 2b. HOUR<br><b>740 P.M.</b>   |   |  |  |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>Caucasian</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 31 00</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>82</b> YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                             |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore County General Hospital</b> |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Home Maker</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Balto. City</b>   |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>6939 Reisterstown Road 21215</b>   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John F. Schmidt</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Louise Gerheart</b> |   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>               |   |  | 16b. SOCIAL SECURITY NO.<br><b>218-40-1251 A</b> |  |
| 17. INFORMANT<br>NAME ADDRESS<br><b>Mrs. Frank Mitchell</b><br><b>5707 French Avenue Sykesville, MD. 21784</b>   |  |   |   |   |   |   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Septic</b><br><b>1629</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Failure of perine</b><br>(c) <b>Out cell carcinoma of lung</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10 days</b> |  |   |   |   |   |   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>ASCD</b>  |  |   |   |   |   |   |   |  |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                        |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>4/5 19 82</b>     |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |  |
| 22a. I certify that (a) (this hospital) attended the deceased from <b>4/5 19 82</b> to <b>4/17 19 82</b> that (b) (we) last saw the deceased alive on <b>4/17</b> 19 <b>82</b> ; and that in (my) (our) opinion death occurred on the date and hour and from the causes stated.  |  |   |   |   |   |   |   |  |  |  |
| 23a. SIGNATURE<br><b>Vikay Narayen</b>   |  |   |   |   |   | DEGREE<br><b>MD</b>   |   | 23c. DATE SIGNED<br><b>4/17/82</b>   |  |  |
| 23b. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>VIKAY NARAYEN</b>  |  |   |   |   |   | 23d. ADDRESS<br><b>5401 OLD COURT Rd</b>  |   |  |  |  |
| 23e. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |   | 23f. DATE<br><b>4-21-82</b>   |   | 23g. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore Cemetery</b>                       |   | 23h. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore City, Maryland</b> |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Loring Byers Funeral Directors, Inc.</b><br><b>8728 Liberty Road Randallstown, Maryland 21133</b>   |  |   |   |   |   | 25a. DATE REC'D. BY REGISTRAR   |   | 25b. REGISTRAR'S SIGNATURE<br><b>James J. Nathan</b>   |  |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 5 6 0

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |   |   |   |  |  |
|--|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>IONE S. COOK</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>APRIL 1, 1982</b>   |  | 2b. HOUR<br>MIN.<br><b>6:45P</b>   |
| 3. SEX<br><b>FEMALE</b>  | 4. RACE<br><b>WHITE</b>                       | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>APRIL 15, 1905</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>76</b> YRS                                     | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR COUNTRY)<br><b>VIRGINIA</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.  |
| 10. CITY OR TOWN OF DEATH<br><b>RANDALLSTOWN</b>   |   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN HOME, GIVE STREET ADDRESS)<br><b>RANDALLSTOWN CONVALESCENT CTR.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b> |  |
| 13a. STATE<br><b>MARYLAND</b>  |   |   | 13b. COUNTY<br><b>BALTIMORE</b>   | 13c. CITY OR TOWN<br><b>RANDALLSTOWN</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>CHARLES ROEHLER STRIGLE</b>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE<br><b>MARY ALICE PARKS</b>   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>220-03-1650</b>  |   | 17. INFORMANT ADDRESS<br><b>FERN S. PINKLEY 3912 NOYES CIRCLE MD.</b>                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>2849</b> IMMEDIATE CAUSE (a) <b>Septic Anemia and sepsis</b>  |   |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>4 1/2 hrs</b>  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF   |   |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>CNS Mass like embolus</b>  |   |   |   |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |   |   |   |  |  |
| 22b. SIGNATURE<br><i>J. Stephen Margolis</i>   |   | DEGREE  |   | 22c. DATE SIGNED<br><b>4/12/82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>J. STEPHEN MARGOLIS</b>  |   | 22e. ADDRESS<br><b>10219 SOUTH DOLFIELD RD. OWINGS MILLS</b>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |   | 23b. DATE<br><b>4/3/82</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>WESTERN CEMETERY</b>                        |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b>  |   | 23e. NAME OF CEMETERY OR CREMATORY<br><b>WESTERN CEMETERY</b>   |   |  |  |
| 24. FUNERAL DIRECTOR'S NAME<br><b>LEROY &amp; RUSSELL WITZKE FUNERAL HOMES</b>   |   | 24b. ADDRESS<br><b>1630 EDMONDSON AVENUE CATONSVILLE MD.</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 2 1982</b>                                   |  |
| 25b. REGISTRAR'S SIGNATURE<br><i>Frances Jean Kistner</i>  |   |   |   |  |  |

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DATE: 1967 JUNE 15 TIME: 11:00 AM

TO: DIRECTOR, FBI (100-3-100) FROM: SAC, NEW YORK (100-3-100)

SUBJECT: JAMES EARL RAY, AKA; MURDER OF MARTIN LUTHER KING, JR.

RE: NEW YORK TELETYPE TO BUREAU, JUNE 14, 1967.

FOR INFORMATION OF THE BUREAU, THE FOLLOWING IS A SUMMARY OF THE MATTER:

ON JUNE 13, 1967, A TELEPHONE CALL WAS RECEIVED AT THE NEW YORK OFFICE OF THE FBI, REPORTING THAT AN INDIVIDUAL HAD INFORMATION CONCERNING THE MURDER OF MARTIN LUTHER KING, JR.

THE INDIVIDUAL STATED THAT HE HAD BEEN CONTACTED BY AN INDIVIDUAL WHO OFFERED HIM \$10,000 TO ASSIST IN THE MURDER OF MARTIN LUTHER KING, JR. THE INDIVIDUAL REFUSED THE OFFER AND REPORTED THE MATTER TO THE FBI.

THE NEW YORK OFFICE IS CURRENTLY ATTEMPTING TO LOCATE THE INDIVIDUAL WHO MADE THE CALL AND IS REQUESTING THE BUREAU TO ASSIST IN THIS EFFORT.

THE BUREAU IS REQUESTED TO ADVISE THE NEW YORK OFFICE OF ANY DEVELOPMENTS THAT MAY BE RECEIVED.

VERY TRULY YOURS,

J. Edgar Hoover

Enclosure

100-3-100

100-3-100

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100-3-100

100-3-100

Item #2a Film G567 5/3/82 rc

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

8 2 0 8 5 6 1

FOR  
1 - STATE  
REGISTRAR

## CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |  |   |
|---|--|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Paul S. Cooley   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>April 21, 1982  |  | 2b. HOUR<br>4 P M                             |
| 3. SEX<br>Male  | 4. RACE<br>White   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Feb. 21, 1912   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>70  | 7. VRS.                                       |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.   |  |   |
| 10. CITY OR TOWN OF DEATH<br>Towson   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>54 Acorn Circle, Apt. 202 |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Service Station-Attendant Amoco  | 12b. KIND OF BUSINESS OR INDUSTRY  |   |
| 13a. STATE<br>Maryland  | 13b. COUNTY<br>Baltimore   | 13c. CITY OR TOWN<br>Towson   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 13e. STREET ADDRESS<br>54 Acorn Circle, Apt. 202   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Ambrose O. Cooley   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Margaret Hopkins   |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>YES   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WW11   | 17. INFORMANT ADDRESS<br>Olive E. Ulrich, 900 W. Baker Ave., Abingdon  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Myocardial Infarction<br>4100 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>Diseased ASCVD<br>DUE TO, OR AS A CONSEQUENCE OF<br>Severe Coronary Arteriosclerosis<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>5-7 yrs |  |   |  |  |   |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |  |   |  |  |   |
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |   |
| 22a. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   | 22b. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   | 22c. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from<br>saw the deceased alive on 3/24/82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death.   |  |   |  |  |   |
| 22b. SIGNATURE<br>Charles F. O'Donnell  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>4/26/82                   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Charles F. O'Donnell, M.D.   |  |   | 22e. ADDRESS<br>7501 York Rd. Towson, Md. 21204  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  | 23b. DATE<br>4-28-82   | 23c. NAME OF CEMETERY OR CREMATORY<br>Parkwood Cemetery   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Parkville, Balto. Maryland   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>Ruck Towson Funeral Home, Inc. Towson, Md. 21204  |  | ADDRESS<br>1050 York Rd.  |  | 25a. DATE REC'D. BY REGISTRAR<br>APR 27 1982   | 25b. REGISTRAR'S SIGNATURE<br>James J. Nathan |

TO HOSPITAL OR ATTENDING PHYSICIAN. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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APR 27 1985

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8-2 08562

REG. NO.

|  |   |   |   |   |   |
|--|---|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>HAROLD L. COWELL   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>April 8, 1982                                |   | 2b. HOUR<br>1:10 P <sub>M</sub>   |
| 3. SEX<br>Male   | 4. RACE<br>White  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Sept. 26 1896   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>85 YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Minn.   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                    |   |
| 10. CITY OR TOWN OF DEATH<br>Towson  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Multi-Medical Center |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Elect. Engineer |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Electrical   |
| 13a. STATE<br>Md.  |   | 13b. COUNTY<br>Balto.   | 13c. CITY OR TOWN<br>Towson   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br>4 Linden Terrace   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William E. Cowell  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Helena Robauer   |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes  |   | 16b. SOCIAL SECURITY NO.<br>WW 1  | 17. INFORMANT<br>ADDRESS<br>Dorothy S. Granger Balto., Md.                          |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Bronchogenic Carcinoma</u><br>1629<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>ASHD</u><br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>7<br>7  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |   |   |   |   |   |
| 19a. DATE OF OPERATION<br>March 1982   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Carcinoma of lung   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>May 3</u> , 19 <u>81</u> , to <u>April 8</u> , 19 <u>82</u> , that (I) (we) lost<br>saw the deceased alive on <u>3/29</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) did (did not) view the body after death.   |   |   |   |   |   |
| 22b. SIGNATURE<br><u>Dr. Sylvan D. Goldberg</u>  |   | DEGREE<br>MD  |   | 22c. DATE SIGNED<br>4/12/82   |   |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Sylvan D. Goldberg, M.D.  |   | 22c. ADDRESS<br>Medical Arts Bldg., Balto., Md.   |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |   | 23b. DATE<br>4-13-82  | 23c. NAME OF CEMETERY OR CREMATORY<br>Springfield                                   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Sykesville Carroll Md.  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Henry W. Jenkins & Sons Co.<br>4905 York Road Balto., Md. 21212  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>APR 13 1982  |   |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 15 minutes after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 5 6 3

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |   |  |   |  |  |  |
|--|--|---|--|---|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>AUGUST CRANE</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 1, 1982</b>            |   |   | 2b. HOUR<br><b>6:00P<sub>M</sub></b>   |   |  |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Feb. 17, 1906</b>  |   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS HOURS MIN.<br><b>76</b> |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Germany</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County, MD.</b>        |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>21234</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>7924 Aiken Avenue</b> |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Cabinetmaker</b> |  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Furniture</b>  |  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>21234</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 13e. STREET ADDRESS<br><b>7924 Aiken Avenue</b>  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>August Max Kranich</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Narie Hildenbrand</b>   |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE YEAR OR DATES)<br><b>216-10-7505</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Hildegard M. Crane Balto., MD 21234</b>  |   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Stroke</b><br><b>4360</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Cerebral arteriosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 year</b> |  |   |  |   |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>None</b>   |  |   |  |   |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Feb. 28</b> , 19 <b>74</b> , to <b>April 1</b> , 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>Mar. 29</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.  |  |   |  |   |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>R. Donald Jandorf</b>   |  |   |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>4-2-82</b>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>R. Donald Jandorf, M.D.</b>  |  |   |  |   |   | 22e. ADDRESS<br><b>7403 Harford Road 444-2424</b>  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |   | 23b. DATE<br><b>Apr. 5, '82</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moreland Mem. Pk.</b>                          |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co., MD</b>      |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>William E. Johnson 8521 Loch Raven Blvd.</b>  |  |   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 2 1982</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Thomas J. Heston</b>  |  |  |

DATE: 10/10/68

TO: Mr. J. Edgar Hoover

FROM: Mr. [illegible]

SUBJECT: [illegible]

RE: [illegible]

1. [illegible]

2. [illegible]

3. [illegible]

4. [illegible]

5. [illegible]

6. [illegible]

7. [illegible]

8. [illegible]

9. [illegible]

10. [illegible]

11. [illegible]

12. [illegible]

13. [illegible]

14. [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |        |   |                   |  |  |                     |     |  |          |
|---|--|---|--------|---|-------------------|--|--|---------------------|-----|--|----------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST   | MIDDLE | LAST  | 2a. DATE OF DEATH |  |  | MONTH               | DAY | YEAR   | 2b. HOUR |
| DOLORES   |  | D   |        | CROMWELL  | 4-6-82            |  |  |                     |     |  | 10:05p   |
| 3. SEX  |  | 4. RACE   |        | 5. DATE OF BIRTH  |                   | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR     |     | IF UNDER 24 HRS                              |          |
| Female  |  | White   |        | June 18, 1892   |                   | 89   |  | MONTHS              |     | DAYS   |          |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                   | 9. BALTIMORE CITY OR COUNTY OF DEATH                                   |  |                     |     |  |          |
| Virginia  |  | USA   |        |   |                   | BALTIMORE COUNTY   |  |                     |     | MD.  |          |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |        | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |                   | 12b. KIND OF BUSINESS OR INDUSTRY                                      |  |                     |     |  |          |
| TOWSON  |  | ST. JOSEPH HOSPITAL   |        | Homemaker   |                   |  |  |                     |     |  |          |
| 13a. STATE  |  | 13b. COUNTY   |        | 13c. CITY OR TOWN   |                   | 13d. INSIDE CITY LIMITS?   |  | 13e. STREET ADDRESS |     |  |          |
| Maryland  |  | Baltimore   |        | Baltimore   |                   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>    |  | 710 Stoneleigh Rd.  |     |  |          |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME  |        | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |                   | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT       |     | ADDRESS                                      |          |
| Victor deMurguiondo   |  | Mary  |        | No  |                   | 577-10-1839  |  | Rev. Dick Cromwell  |     | Same   |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u><br><u>7532</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Renal Failure</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>CONGENITAL URETERO-PELVIC JUNCTION OBSTRUCTION</u><br><u>congenital ureteropelvic junction obstruction</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u> |  |   |        |   |                   |  |  |                     |     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |          |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |        | 20a. AUTOPSY?   |                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?         |  |                     |     |  |          |
|   |  |   |        | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                   | YES <input type="checkbox"/> NO <input type="checkbox"/>               |  |                     |     |  |          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |        | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)  |                   |  |  |                     |     |  |          |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |        | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                   |  |  |                     |     |  |          |
| 22a. I certify that (X) (this hospital) attended the deceased from <u>2-16</u> 19 <u>82</u> , to <u>4-6</u> 19 <u>82</u> , that (X) (we) last saw the deceased alive on <u>4-6</u> 19 <u>82</u> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (do not) view the body after death.   |  |   |        |   |                   |  |  |                     |     |  |          |
| 22b. SIGNATURE<br><u>Hafez Ali K Zrebeet</u>  |  | DEGREE<br>M.D.  |        | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |                   | 22c. DATE SIGNED<br><u>4/6/82</u>                                      |  |                     |     |  |          |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>HAFEZ ALI K. ZREBEET, M.D.   |  | 22e. ADDRESS<br>7620 YORK ROAD TOWSON MD 21204  |        |   |                   |  |  |                     |     |  |          |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>April 7, 1982  |        | 23c. NAME OF CEMETERY OR CREMATORY<br>Green Mount   |                   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore City, Maryland |  |                     |     |  |          |
| 24. FUNERAL DIRECTOR<br>NAME<br>Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212   |  | ADDRESS<br>6500 York Rd.  |        | 75a. DATE REC'D BY REGISTRAR<br>APR 14 1982   |                   | 75b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>                       |  |                     |     |  |          |

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James J. Lee

White

Female

USA

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8625 HOERNER AVE 21234 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 2 0 8 5 6 5  
 CERTIFICATE OF DEATH

|  |  |   |   |  |  |
|--|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>JACK MARTIN CROOP</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4-17-82</b>                             |  | 2b. HOUR<br><b>3:30 AM</b>   |
| 3. SEX<br><b>MALE</b>  | 4. RACE<br><b>CAUCASION</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2-8-11</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b> YRS.                                 |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>OHIO</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE County</b> MD.               |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Parkville</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>PEARING PARKWAY NURSING HOME</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>CLERGY</b> | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>Maryland</b>  |  |   | 13b. COUNTY<br><b>Baltimore</b>   | 13c. CITY OR TOWN<br><b>Parkville</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Alfonzo</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Matilda Martin</b>            |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>220-34-6059</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>Mrs. June Croop Parkville, Maryland 21234</b>                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Arteriosclerotic Vascular Dis-</b><br><b>4370</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>A.S.C.V.D.</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>         | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>4/17/82 4:17 P.M.</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>1801 Westlawn Rd Baltimore 21234</b> |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>4/17/82 4:17</b> to <b>4/17/82</b> , that (I) (we) lost saw the deceased alive on <b>4/17/82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |   |   |  |  |
| 23a. SIGNATURE<br><b>Anthony F. Caron, M.D.</b>  |  |   |   | 23b. DATE SIGNED<br><b>4/18/82</b>   |  |
| 23c. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Anthony F. Caron, M.D.</b>   |  |   |   | 23d. ADDRESS<br><b>1801 Westlawn Rd Baltimore 21234</b>                                      |  |
| 23e. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23f. DATE<br><b>April 19, 1982</b>  |   | 23g. NAME OF CEMETERY OR CREMATORY<br><b>Highland Cemetery</b>                               |  |
| 23h. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Street Harford Maryland</b>   |  | 23i. DATE REC'D. BY REGISTRAR<br><b>APR 19 1982</b>   |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, Maryland 21133</b>   |  |   |   | 25. REGISTRAR'S SIGNATURE<br><b>James J. Nathan</b>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. If 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 8 2 0 8 5 6 6<br>REG. NO.   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1 - FOR STATE REGISTRAR  |  |  |  | 1. DECEASED NAME (TYPE OR PRINT)  |  |   |  |
| FIRST MIDDLE LAST<br><b>CHARLES Edgar CROWLEY</b>  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>4/23/82</b>  |  |   |  |
| 3 SEX<br><b>Male</b>   |  |  |  | 4 RACE<br><b>White</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>12-20-05</b>  |  |
| 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>76</b>  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE</b> County MD.   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>   |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>6701 N CHARLES ST GBMC</b>               |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Dir. Ind. Rel.</b>  |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>MartinMarrietta</b>  |  |  |  | 13a. STREET ADDRESS<br><b>909 Malvern Ave 21204</b>   |  |   |  |
| 13b. COUNTY<br><b>Baltimore</b>  |  |  |  | 13c. CITY OR TOWN<br><b>Towson</b>  |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>George Sullivan Crowley</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Augusta Traband</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>   |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>215-03-6025</b>  |  | 17. INFORMANT ADDRESS<br><b>Marie M. Crowley 909 Malvern Ave 21204</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>SEPTIC SHOCK</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>RENAL FAILURE</b> |  |  |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) |  |   |  |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY OFFICE FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>APRIL 2 19 82</b> , to <b>APRIL 23 82</b> , that (I) (we) lost above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Samuel Jacobs MD</b>  |  |  |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>4/23/82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BR S JACOBS</b>  |  |  |  | 22e. ADDRESS<br><b>GBMC</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |  |  | 23b. DATE<br><b>4-26-82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cem</b>  |  |
| 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 28 1982</b>   |  |   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Mitchell-Wiedefeld Home</b>  |  |  |  | 25b. REGISTRAR SIGNATURE<br><b>[Signature]</b>  |  |   |  |

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STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

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REG. NO.

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Margaret E. CZYZECHOWICZ</b>  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 14, 1982</b>  |  | 2b. HOUR<br><b>2:00 a.m.</b>  |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>JAN 5 1926</b>   |  |
| 6. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>FRANKLIN SQUARE</b> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.   |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SEAMSTRESS</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>MONTGOMERY WARD</b>   |  |   |  |
| 13a. STATE<br><b>MD.</b>   |  | 13b. COUNTY<br><b>BALTIMORE</b>   |  | 13c. CITY OR TOWN<br><b>BALTO.</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JACOB BAYER</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>CATHERINE LOTZ</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>216 20 2581</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>FRANK CZYZECHOWICZ 3944 NEW SECTION RD.</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio-pulmonary Arrest</b><br><b>5860</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) <b>Probable Myocardial Infarct</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Probable Renal Failure</b>   |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>April 13</b> 19 <b>82</b> , to <b>April 14</b> 19 <b>82</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>April 14</b> 19 <b>82</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did not view the body after death. |  |   |  |   |  |
| 22b. SIGNATURE<br><b>G. Gonzalez, M.D.</b>   |  | DEGREE<br><b>M.D.</b>   |  | 22c. DATE SIGNED<br><b>4/14/82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>G. Gonzalez, M.D.</b>  |  | 22e. ADDRESS<br><b>9000 Franklin Square Drive 21237</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>4/17/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>SAC. HEART OF JESUS</b>  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MD</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 16 1982</b>   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>RAYMOND L. KACZOROWSKI</b>  |  | ADDRESS<br><b>2525 FLEET ST</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |

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*[Signature]*

NO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-368-1234.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO. 8 2 0 8 5 6 8  |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Richard H. DAFFRON  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>4-24-82   |  |  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>2 4 1915   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>67 YRS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Tennessee   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Rossville   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Franklin Square Hospital |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Foreman  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Beth. Steel   |  |
| 13a. STATE<br>Maryland   |  |  |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Edgemere  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Silas Daffron   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Frances   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>212-03-5230  |  | 17. INFORMANT ADDRESS<br>Margaret G. Daffron Balto., MD. 21219  |  |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardio respiratory arrest<br>1629<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Lung and stomach cancer<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)<br><input type="checkbox"/>  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that X (this hospital) attended the deceased from April 2, 19 82, to April 24, 19 82, that X (we) last saw the deceased alive on April 24, 19 82, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (b) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br>Eduardo Dieguez MD   |  |  |  |   |  | 22c. DATES SIGNED<br>4/24/82   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>EDUARDO DIEGUEZ JR  |  |  |  |   |  | 22e. ADDRESS<br>9000 Franklin Square Dr., 21237  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>4/27/1982   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Oak Lawn  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore MD.   |  |
| 24. FUNERAL DIRECTOR NAME<br>Duda-Ruck, Inc.<br>7922 Wise Avenue Dundalk, MD. 21222  |  |  |  | 25a. DATE REC'D BY REGISTRAR<br>APR 27 1982   |  |  |  |
|  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br>Frances Sam Nathan  |  |  |  |

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UNITED STATES DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT



APR 27 1983

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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|--|--|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>EARL EDWARD DAY</b>   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4/22/82</b>   |  | 2b. HOUR<br><b>8:20</b><br>P M  |
| 3. SEX<br><b>MALE</b>  | 4. RACE<br><b>WHITE</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 3 20</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>61</b> YRS.<br>IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>KENTUCKY</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.                             |
| 10. CITY OR TOWN OF DEATH<br><b>FORT HOWARD</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>V. A. MEDICAL CENTER</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>ENGINEER</b>  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Canton R. R.</b>  |
| 13a. STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>BALTIMORE</b>   | 13c. CITY OR TOWN<br><b>DUNDALK</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>DAVE H. DAY</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ETHEL HALL</b>  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>   | (IF YES, GIVE WAR OR DATES)<br><b>WWII</b>   | 16b. SOCIAL SECURITY NO.<br><b>407 09 3497</b>  | 17. INFORMANT<br>ADDRESS<br><b>CLINICAL RECORDS, VAMC, FORT HOWARD, MD</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>SQUAMOUS CELL CARCINOMA OF LUNG</b><br><b>1629</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 YEAR</b>                   |  |   |  |   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>HYPERTENSION</b>  |  |   |  |   |
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>3/30/</b> 19 <b>82</b> , to <b>4/22</b> , 19 <b>82</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>4/22</b> , 19 <b>82</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did (did not) view the body after death. |  |   |  |   |
| 22b. SIGNATURE<br><i>A. K. Chopra</i>  | DEGREE<br><b>M.B.B.S.</b>  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>       | 22c. DATE SIGNED<br><b>4/22/82</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>A. K. CHOPRA, M. D.</b>  |  | 22e. ADDRESS<br><b>V.A.M.C., FORT HOWARD, MD 21052</b>  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Entombment</b>  | 23b. DATE<br><b>4/26/82</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holly Hill Memorial</b>  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>White Marsh, Baltimore, MD</b>  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Duda-Ruck, Inc.</b>   |  | ADDRESS<br><b>7922 Wise Avenue, Dundalk, MD 21222</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 26 1982</b>   |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

NO 1 1947

THURSDAY

1947

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NOT ON ONLY - MINERAL BROWN, WHITE, AND RED, 1947

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 5 7 0

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|  |  |   |   |  |  |
|--|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>CATHERINE DEARHOLT</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4/13/82</b>   |  | 2b. HOUR<br><b>9:30P<sup>M</sup></b>   |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>March 21, 1918</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>64</b>                                   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |
| 7. BIRTHPLACE (STATE OR FOREIGN)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>TOWSON</b> MD.                      |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>GBMC 6701 N CHARLES ST</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  | 13b. COUNTY<br><b>Baltimore</b>  | 13c. CITY OR TOWN<br><b>Parkville</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br><b>2801 Taylor Avenue</b>                               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Jeffer G. Harris, Sr.</b>   |  | 15. MOTHER'S MAIDEN NAME<br>MAY MEYERS<br><b>Barbara May Meyers</b>   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>212-14-2644</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Mr. Howard L. Dearholt 2801 Taylor Avenue</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ADENO CARCINOMA COLON LIVER METASTASIS</b><br><b>1539</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>CARCINOMATOSIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |   |  |  |
| 22b. SIGNATURE<br><i>[Signature]</i>   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |   | 22c. DATE SIGNED<br><b>4.13.82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR FLEISCHER</b>   |  | 22e. ADDRESS<br><b>GBMC</b>   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>4-17-1982</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood</b>                          |  |
| 23d. LOCATION<br>CITY OR TOWN<br><b>Baltimore</b>  |  | COUNTY<br><b>Maryland</b> STATE   |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Ruck Towson Funeral Home, Inc.</b>  |  | ADDRESS<br><b>1050 York Road Towson, Maryland</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 16 1982</b>                            |  |
|  |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |   |  |  |

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ALLIANCE 1072 2701 CHARLES ST

ARMED ASSOCIATION C-101 LI-101 2701

CARROLLTON

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CLARENCE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |  |   | 8 2 0 8 5 7, 1 |  |
|---|--|--|--|---|--|---|--|--|---|----------------|--|
| 1. FOR STATE REGISTRAR  |  |  |  |   |  |   |  |  |   | REG. NO.       |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>JOSEPH DELTUVA</b>  |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>04 24 82</b>   |   |  | 2b. HOUR<br><b>6:30 A M</b>  |   |                |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>02 07 1892</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><b>90</b>                  |  | 7. IF UNDER 1 YEAR<br>IF UNDER 24 HRS.<br>HOURS MIN.<br><b>00 00</b> |   |                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>LITHUANIA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY MD.</b>               |  |  |   |                |  |
| 10. CITY OR TOWN OF DEATH<br><b>HALETHORPE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>914 FRANCIS AVENUE</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>TAILOR</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>CLOTHING</b>                 |   |                |  |
| 13a. STATE<br><b>MARYLAND</b>   |  |  |  |   | 13b. COUNTY<br><b>BALTIMORE</b>  |   | 13c. CITY OR TOWN<br><b>ARBUTUS</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ANTHONY DELTUVA</b>  |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>U N K N O W N</b>  |   |  |  |   |                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>215-03-5702</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>EDWARD V. DELTUVA 4615 BENSON AVENUE</b>   |  |   |  |  |   |                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>MYO CARDIAL INFARCTION</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |   |  |   |  |  |   |                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>GANGRENE BOTH LEGS (ATHEROSCLEROTIC)</b>   |  |  |  |   |  |   |  |  |   |                |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |                |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)  |  |   |  |  |   |                |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |   |                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |  |  |   |                |  |
| 22b. SIGNATURE<br><i>Keith D. Falcao</i> DEGREE   |  |  |  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |  | 22c. DATE SIGNED<br><b>4/24/82</b>                                   |   |                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>KEITH D. FALCAO, M.D.</b>   |  |  |  |   | 22e. ADDRESS<br><b>3350 WILKENS AVENUE, 21229</b>  |   |  |  |   |                |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>CREMATION</b>  |  | 23b. DATE<br><b>04-27-82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>LOUDON PARK</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE CITY MARYLAND</b>      |  |  |   |                |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE. 21229</b>   |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>APR 26 1982</b> <i>Thane J. North</i>                                       |   |  |  |   |                |  |

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TREASURER  
OF THE  
UNITED STATES  
DEPARTMENT OF  
THE INTERIOR  
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D. C.

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TO THE  
COMMISSIONER  
OF THE  
LAND OFFICE  
WASHINGTON  
D. C.

FOR THE  
PURPOSE OF  
RECORDING  
THE  
LANDS  
OF THE  
UNITED STATES  
DEPARTMENT OF  
THE INTERIOR  
WASHINGTON  
D. C.

APR 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be contacted as per page 35.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |   |   |   |  |   |  |   | REG. NO. 8 2 0 8 5 7 2                        |  |
|---|--|---|---|---|---|--|---|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Gustave William DEPOITIERS</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 16, 1982</b>            |   |   | 2b. HOUR<br><b>9:55 p.m.</b>   |   |  |   |   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 12 22</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>60</b>   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>YRS.</b>  |   | IF UNDER 24 HRS.<br>HOURS MIN.<br><b>YRS.</b> |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.  |   |  |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rossville</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Sq. Hospital</b> |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Policeman</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Balto. Cty.</b>  |   |   |  |
| 13a. STATE<br><b>Maryland</b>   |  |   | 13b. COUNTY<br><b>Baltimore</b>   |   | 13c. CITY OR TOWN<br><b>Rosedale</b>                          |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>7407 Barkdoll Ct. 21237</b> |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Gustave W. DePoitiers</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Bertha Redhead</b>  |   |   |  |   |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WW II</b> |   | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Patricia DePoitiers</b>   |  |   | 7407 Barkdoll Ct. 21237 p.c.   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiogenic Shock</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Probable Acute Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |   |   |   |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)  |  |   |   |   |   |  |   |  |   |   |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                        |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>       |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |   |   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>April 9, 1982</b> to <b>April 16, 1982</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>April 16, 1982</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (not) view the body after death. |  |   |   |   |   |  |   |  |   |   |  |
| 22b. SIGNATURE<br><b>P.A. Baltatzis MD.</b>   |  |   |   |   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>4-16-82</b>   |   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>P. A. Baltatzis, M.D.</b>   |  |   |   |   |   | 22e. ADDRESS<br><b>9000 Franklin Square Drive, 21237</b>   |   |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |   | 23b. DATE<br><b>4-20-82</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardens of Faith</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Overlea Balto. Md.</b>                         |  |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Lassahn Funeral Home, Inc.</b>   |  |   |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 22 1982</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |   |   |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 2 0 8 5 7 3  
CERTIFICATE OF DEATH

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|  |  |   |   |  |  |
|--|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>William Edward DERRETH, Jr.</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4 8 82</b>  |  | 2b. HOUR<br><b>8:27 PM</b>   |
| 1. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Feb. 16, 1921</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>61</b> YRS.   | 8. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>0 0 0 0</b>                       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County MD.</b>                             |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Balto. County Gen. Hosp.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Sales Mgt.</b>           | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Safety Protection</b>                        |  |
| 13a. STATE<br><b>Md.</b>   | 13b. COUNTY<br><b>Carroll</b>  | 13c. CITY OR TOWN<br><b>Sykesville</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br><b>8354 ERIN Rd.</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William E. Derreth, Sr.</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Nellie Emich</b>                            |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>yes WWII</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>21716 0762</b>   | 17. INFORMANT<br>ADDRESS<br><b>Mildred Derreth Sykesville, Md.</b>                              |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute myocardial Infarction</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>ASCD</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Immediate</b>   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____   |  |   |   |  |  |
| 19a. DATE OF OPERATION<br><b>—</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>—</b>  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>— P.M. 19</b>   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>2/4</b> 19 <b>69</b> , to <b>4/8</b> 19 <b>82</b> , that (1) (we) last saw the deceased alive on <b>4/5</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.                                 |  |   |   |  |  |
| 22b. SIGNATURE<br><b>Morton J. Ellin</b>   |  | DEGREE<br><b>M.D.</b>   |   | 22c. DATE SIGNED<br><b>4-9-82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Morton J. Ellin, M.D.</b>  |  | 22e. ADDRESS<br><b>5310 Old Court Rd. Randallstown, Md.</b>   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SEE INSTRUCTIONS)<br><b>Burial</b>   | 23b. DATE<br><b>4-12-82</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lake View Cemetery</b>   | 23d. LOCATION<br>CITY OR TOWN COUNTY<br><b>Sykesville Carroll Md.</b>                           |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Harry W. Haight</b>   |  | ADDRESS<br><b>Sykesville, Md.</b>   | 19a. DATE REC'D. BY REGISTRAR 19b. REGISTRAR'S SIGNATURE<br><b>APR 14 1982</b>                  |  |  |

MEDICAL CERTIFICATION

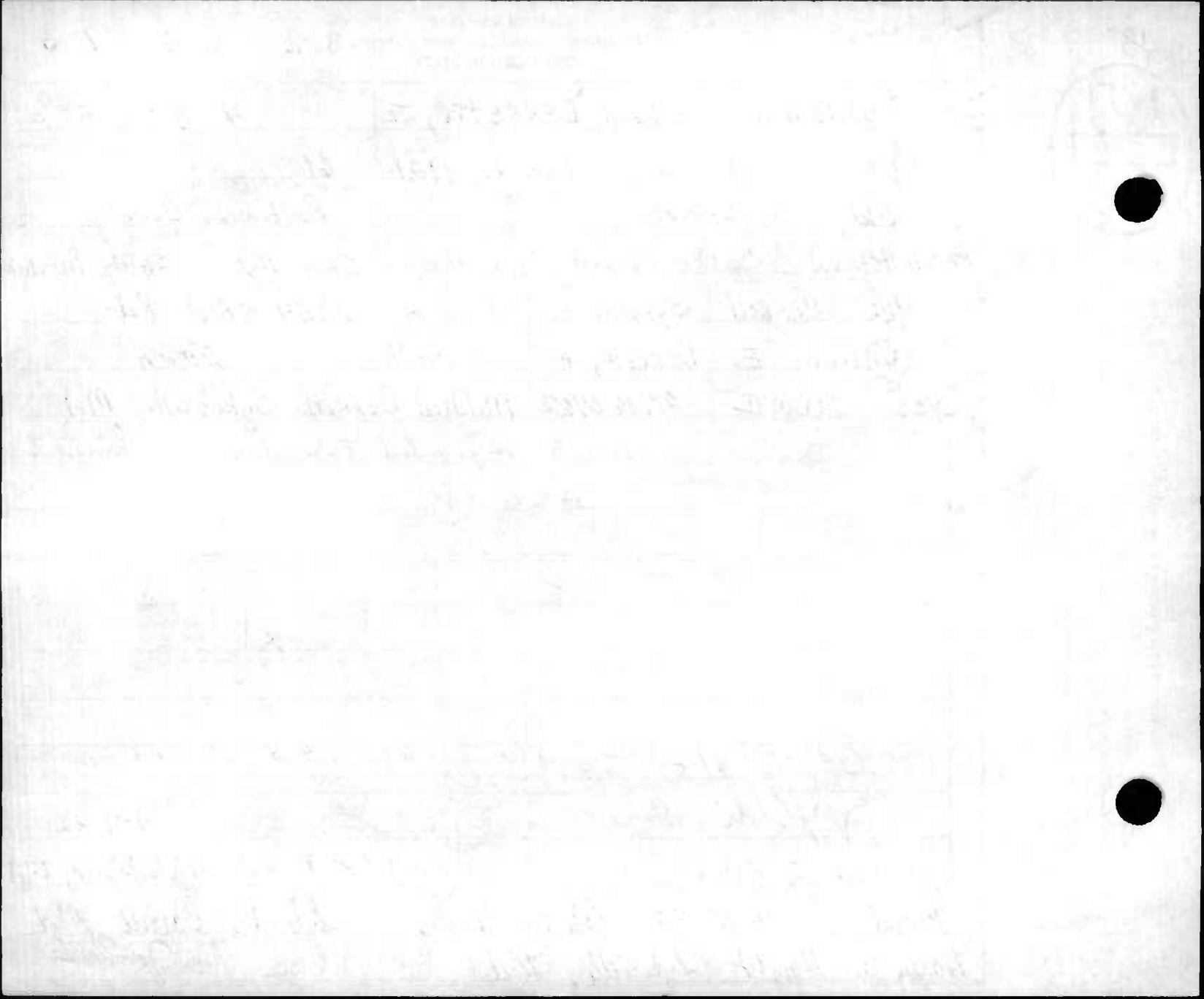
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 5 7 4

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |   |   |   |  |   |
|--|---|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>VIOLA EMMMA DINSMORE   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>04 23 82                               |  | 2b. HOUR<br>3 <sup>05</sup> P.M.  |
| 3. SEX<br>FEMALE   | 4. RACE<br>CAUCASION  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>08 19 10  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>71 YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                         |   |
| 10. CITY OR TOWN OF DEATH<br>Randallstown  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Baltimore County General Hosp. |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife |  | 12b. KIND OF BUSINESS OR INDUSTRY   |
| 13a. STATE<br>Maryland   |   |   | 13b. COUNTY<br>Balto.   | 13c. CITY OR TOWN<br>Reisterstown  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                       |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Fred Kochler   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>LuLa Stuhr                   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |   | 16b. SOCIAL SECURITY NO.<br>219-20-9245   |   | 17. INFORMANT<br>ADDRESS<br>203 Sunnyking Dr.<br>Reisterstown, Md.                   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIO-PULMONARY ARREST</u><br><u>4100</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <u>ACUTE MYOCARDIAL INFARCTION</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>—</u> |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |   |   |   |  |   |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4-22-1982</u> to <u>4-23-1982</u> , that (I) (we) lost saw the deceased alive on <u>4-23-1982</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |   |   |   |  |   |
| 22b. SIGNATURE<br><u>[Signature]</u>   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |   | 22c. DATE SIGNED<br>4-23-82  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DR. SUDHIR. PATEL   |   | 22e. ADDRESS<br>Bal. County Gen. Hosp.  |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   | 23b. DATE<br>April 26, 1982   | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park Cem.  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md.                          |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>James B. Eckhardt  |   | ADDRESS<br>11605 Reisterstown Rd.   |   | 25a. DATE REC'D. BY REGISTRAR<br>APR 27 1982   | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |

MEDICAL CERTIFICATION





TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |                             |  | 8 2 0 8 5 7 5   |     |            |  |  |
|--|--|--|--|--|--|--|--|-----------------------------|--|-----------------|-----|------------|--|--|
| 1- FOR<br>STATE<br>REGISTRAR   |  | REG. NO.   |  |  |  |  |  |                             |  |                 |     |            |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST  |  | MIDDLE   |  | LAST   |  | 2a. DATE OF DEATH           |  | MONTH           | DAY | YEAR       | 2b. HOUR                                     |  |
| DOROTHY  |  | Elizabeth  |  | DISNEY   |  |  |  | 04                          |  | 30              | 82  | 6          | 55 PM  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR             |  | IF UNDER 24 HRS |     |            |  |  |
| FEMALE   |  | CAUCASION  |  | 10 29 05   |  | 76 YRS.  |  | MONTHS                      |  | DAYS            |     | HOURS MIN. |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |                             |  |                 |     |            |  |  |
| Maryland   |  | USA  |  |  |  | Baltimore County   |  |                             |  |                 |     | MD.        |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |                             |  |                 |     |            |  |  |
| Randallstown   |  | Baltimore County General   |  | Office Manager   |  | Alban Tractor Co   |  |                             |  |                 |     |            |  |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?   |  | 13e. STREET ADDRESS         |  |                 |     |            |  |  |
| Maryland   |  | Baltimore  |  | Randallstown   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 9202 Samoset Rd.            |  | 21133           |     |            |  |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |  |                             |  |                 |     |            |  |  |
| FIRST MIDDLE LAST  |  | FIRST MIDDLE LAST  |  |  |  |  |  |                             |  |                 |     |            |  |  |
| James W Arnold   |  | Anna Rosa Hook   |  |  |  |  |  |                             |  |                 |     |            |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)   |  | 17. INFORMANT  |  | ADDRESS  |  |                             |  |                 |     |            |  |  |
| No   |  | ---  |  | 217-12-3799  |  | Walter Disney  |  | 9202 Samoset Rd.            |  |                 |     |            |  |  |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u><br>4100 WITH<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>PULMONARY OEDEMA</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(c) <u>ARTERIOSCLEROTIC HEART DISEASE</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a |  |  |  |  |  |  |  |                             |  |                 |     |            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?   |  |                             |  |                 |     |            |  |  |
|  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |                             |  |                 |     |            |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)   |  |  |  |                             |  |                 |     |            |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)                                  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |                             |  |                 |     |            |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4-28-1982</u> to <u>4-30-1982</u> , that (I) (we) lost saw the deceased alive on <u>4-30-1982</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  | 22b. SIGNATURE<br><u>[Signature]</u>   |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>4-30-82 |  |                 |     |            |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |  |  |  |  |                             |  |                 |     |            |  |  |
| DR. SUDHIR. PATEL  |  | BAL. COUNTY GEN. HOSPITAL  |  |  |  |  |  |                             |  |                 |     |            |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |                             |  |                 |     |            |  |  |
| Burial   |  | 5/4/82   |  | Woodlawn Cemetery  |  | Woodlawn Baltimore Md  |  |                             |  |                 |     |            |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |                             |  |                 |     |            |  |  |
| 8728 Liberty Rd. Randallstown, Md.<br>Loring Byers Funeral Directors, Inc. 21133   |  | MAY 4 1982   |  | Frances Jan [Signature]  |  |  |  |                             |  |                 |     |            |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | 8 2 0 8 5 7 6  |  |  |  |
|--|--|---|--|--|--|--|--|
| 1. STATE REGISTRAR   |  |   |  | CERTIFICATE OF DEATH   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |   |  | 2a. DATE OF DEATH  |  |  |  |
| FIRST MARY MIDDLE GRACE LAST DISNEY  |  |   |  | MONTH DAY YEAR HOUR<br>4 27 82 5:30 P.M.   |  |  |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                |  |
| Female   |  | White   |  | June 27, 1903  |  | 78   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |  |
| Owings Mills   |  | USA   |  |  |  | Baltimore Co. MD.  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION             |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| Owings Mills   |  | 10620 Reisterstown Rd.  |  | Retired Western Electric   |  |  |  |
| 13a. STATE   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?                                       |  |
| Md.  |  | Balto.  |  | Owings Mills   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  |  |
| E. Nelson  |  | M. Grace Bower  |  | No   |  |  |  |
| 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | ADDRESS  |  |  |  |
| 217-05-6966  |  | Mr. E. Bennett Bowen  |  | Owings Mills, Md.  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |
| IMMEDIATE CAUSE (a) 1539 Carcinoma - Colon with metastasis   |  |   |  | Dec 1980   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) Metastasis  |  |   |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|  |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from July 1976 to April 27, 1982, that (I) (we) lost the deceased alive on April 20, 1982 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |  |  |
| 22b. SIGNATURE   |  |   |  | DEGREE   |  | 22c. DATE SIGNED   |  |
| O.E. McWilliams M.D.   |  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  | 4-27-82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |   |  | 22e. ADDRESS   |  |  |  |
| O.E. McWilliams M.D.   |  |   |  | 1904 Reisterstown Rd, Reisterstown Md 21136  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                        |  |
| Burial   |  | April 30, 82  |  | Druid Ridge Cemetery   |  | Pikesville, Md.  |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS  |  |   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE                                     |  |
| Eline Funeral Home Reisterstown, Md. 21136   |  |   |  | APR 30 1982  |  | [Signature]  |  |

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• 52 interesting ideas

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 2 0 8 5 7 7  
CERTIFICATE OF DEATH

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |  |  |   |  |  |  |
|--|--|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Rev. FRANK D. DIXON</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>APRIL 27, 1982</b> |  |  | 2b. HOUR<br>MIN.<br><b>11 A</b>   |  |  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>BLACK</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 / 1 / 95</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b> YRS.   |  | 7. UNDER 1 YEAR<br>MONTHS DAYS<br><b>86</b>  |  |
| 7a. BIRTHPLACE<br>STATE OR FOREIGN COUNTRY<br><b>TEXAS</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CO MD</b>                                  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE CITY</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>2 CARROLL AVE</b> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RETIRED</b>              |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>BALTIMORE</b>   |  | 13c. CITY OR TOWN<br><b>CATONSVILLE</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>2 CARROLL AVE BALTO MD. 21228</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JOHN DIXON</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MINNIE DIXON</b>   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>713 10 2779</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Mrs CATHERINE DIXON 2 CARROLL AVE</b>   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of Stomach</b><br><b>1519</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>possible metastasis</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>chronic congestive heart failure</b> |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>chronic renal failure, atherosclerosis</b>  |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>2000 W. FAYETTE BALTIMORE MD. 21223</b>  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4/21</b> , 19 <b>82</b> , to <b>4/27</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>4/21</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the cause stated above, (I) (we) (did) (did not) view the body after death. <b>patient pronounced dead at home (office based)</b>      |  |   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>BERNARDO D. GONZALES</b>  |  |   |  | DEGREE <b>MD</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   |  | 22c. DATE SIGNED<br><b>April 27 82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BERNARDO D. GONZALES</b>   |  |   |  | 22e. ADDRESS<br><b>2000 W. FAYETTE, BALTIMORE MD. 21223</b>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>5-1-82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ARABUTUS MEM PK</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ARABUTUS BALTO CO MD</b>                       |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>JOSEPH L. RUSS 2222 W. NORTH AVE</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 4 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Anna Jan North</b>   |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-338-2777.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 2 0 8 5 7 8  
CERTIFICATE OF DEATH

|   |  |  |  |
|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  | REG. NO.   |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | 2a. DATE OF DEATH  |  |
| FIRST MIDDLE LAST<br>Rachel L. Dixon  |  | MONTH DAY YEAR HOUR<br>4 17 82 10:30 P   |  |
| 3. SEX  | 4. RACE  | 5. DATE OF BIRTH   | 6. AGE (IN YEARS LAST BIRTHDAY)  |
| Female  | White  | MONTH DAY YEAR<br>7 14 1891  | 90 YRS   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH   |
| Maryland  | U.S.A.   |  | Baltimore, County MD.  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| Dundalk   | 7219 Martell Ave.  | Homemaker  | Home   |
| 13a. STATE  | 13b. COUNTY  | 13c. CITY OR TOWN  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| Maryland  | Balto.   | Dundalk  | 13e. STREET ADDRESS  |
|   |  |  | 7219 Martell Ave. 21222  |
| 14. FATHER'S NAME   | 15. MOTHER'S MAIDEN NAME   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)  |  |
| FIRST MIDDLE LAST<br>John Arthur  | FIRST MIDDLE LAST<br>Clydie Unknown  | 16b. SOCIAL SECURITY NO. 213 52 2561   |  |
| 17. INFORMANT ADDRESS   |  | 21222  |  |
| 17a. Mrs. Ruby Doxzen-7220 Martell Ave.   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hypostatic Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>HASCD &amp; CHF</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>4029</u>  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>                                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 2</u> , 19 <u>80</u> , to <u>April 18</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>April 16</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. |  |  |  |
| 22b. SIGNATURES   |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |
| Dr. Benigno Lazaro  |  | 59 Dundalk Ave. Balto. Md. 21222   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   | 23b. DATE  | 23c. NAME OF CEMETERY OR CREMATORY   | 23d. LOCATION CITY OR TOWN COUNTY STATE  |
| Burial  | 4/20/82  | Gardens of Faith   | Balto. Md.   |
| 24. FUNERAL DIRECTOR  |  | 25a. DATE REC'D. BY REGISTRAR  |  |
| Duda-Ruck Inc. 7922   |  | 25b. REGISTRAR'S SIGNATURE   |  |
| Wise Ave. 21222   |  | APR 21 1982  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1015 Carroll Ave. 31222

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1015 Carroll Ave. 31222



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

8 2 0 8 5 7 9

1- FOR  
STATE  
REGISTRAR

JOSEPH J. DOLAN SR. CERTIFICATE OF DEATH

REG. NO.

|   |   |   |   |  |  |  |
|---|---|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Dolan SR. Joseph J.  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>April 28, 1982   |  | 2b. HOUR<br>11:04 pm   |  |
| 3. SEX<br>Male  | 4. RACE<br>White  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3 23 1898   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>84   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Baltimore  | 7b. CITIZEN OF WHAT COUNTRY?<br>America   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                    |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore County   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>7934 Berk Lane 21237 | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Truck Driver  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Trucking  |  |  |
| 13a. STATE<br>Maryland  | 13b. COUNTY<br>Baltimore  | 13c. CITY OR TOWN<br>ROSEDALE   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br>7934 Berk Lane 21237  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>JOHN DOLAN  |   | 15. MOTHER'S MAIDEN NAME<br>MIDDLE LAST<br>MARY ROTH  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Unknown NO  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>212-10-5861  | 17. INFORMANT<br>ADDRESS:<br>Franklin Square Hospital<br>C.B. Andrews, M.D. 9000 Franklin Square Dr.  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardio Pulmonary Arrest<br>4273<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) Chronic Obstructive Pulmonary Diseases<br>(c) Chronic Atrial Fibrillation |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  |   |   |   |  |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |  |
| 22a. I certify that (1) this hospital attended the deceased from August 28, 1980, to April 27, 1982, that (2) (we) last saw the deceased alive on April 20, 1982, and that in my (our) opinion death occurred on the date and hour and from the causes stated above; (If we) (did) (did not) view the body after death.                             |   |   |   |  |  |  |
| 22b. SIGNATURE<br>Clarke B. Andrews MD  |   | DEGREE<br>MD  |   | DATE SIGNED<br>April 29, 1982  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Clarke Andrews, M.D.   |   | 22e. ADDRESS<br>Family Health Center<br>Franklin Square Hospital<br>9101 Franklin Square Drive 21237  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  | 23b. DATE<br>5/1/82   | 23c. NAME OF CEMETERY OR CREMATORY<br>OAKLAWN CEMTERY   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO BALTO MARY                       |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Jef Coat  |   | ADDRESS<br>1211 Chesaw Ave.   |   | 25a. DATE REC'D. BY REGISTRAR<br>APR 30 1982   |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

08379

11:04 pm

April 23, 1968

Joseph

John

April 23, 1968

White

John

Baltimore County

White

Baltimore

Truck Driver

Baltimore County 7034 Park Lane 21237

7034 Park Lane 21237

Baltimore

White

Franklin Square Hospital  
Franklin Square Drive

212-10-3001 C.D. Andrews, M.D.

Cardio Pulmonary Arrest

Chronic Obstructive Pulmonary Disease

Chronic Atrial Fibrillation

August 28, 1968

April 20, 1968

Franklin Square Hospital  
Franklin Square Drive

Charles Andrews, M.D.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 2 0 8 5 8 0  
CERTIFICATE OF DEATH

|  |   |  |   |
|--|---|--|---|
| 1. FOR<br>STATE<br>REGISTRAR   |   | REG. NO.   |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Ruth Adele Donachy   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>April 8, 1982<br>2b. HOUR<br>8A M   |   |
| 3 SEX<br>Female  | 4. RACE<br>White  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>April 1, 1921  |   |
| 6a. BIRTHPLACE<br>(STATE OR FOREIGN<br>COUNTRY)<br>Pennsylvania  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 6 AGE [IN YEARS LAST BIRTHDAY]<br>61 YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |
| 7a. CITY OR TOWN OF DEATH<br>Randallstown  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Baltimore County Gen | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County, MD.  |   |
| 10. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MD.   | 13b. COUNTY<br>Howard   | 13c. CITY OR TOWN<br>Baltimore   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Waitress  |
| 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 13e. STREET ADDRESS<br>7734 Washington Blvd.  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>Restaurant   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Alfred M. Bowen  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mabel E. Button  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |   |
| 16b. SOCIAL SECURITY NO.<br>169.24.4343  | 17. INFORMANT (Husband)<br>Mr. Lawrence G. Donachy  | ADDRESS<br>Same as # 13  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Lymphoma - metastatic</u><br><u>2028</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____   |   |  |   |
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>May 1978</u> to <u>April 8, 1982</u> , that (I) <del>(we)</del> lost<br>saw the deceased alive on <u>April 8, 1982</u> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated<br>above, (I) <del>(we)</del> (did) (did not) view the body after death.     |   |  |   |
| 22b. SIGNATURE<br><u>Marshall A. Levine</u>  |   | DEGREE<br>MD<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED<br>4/8/82  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Marshall A. Levine  |   | 22e. ADDRESS<br>711 W. 404th St. Baltimore, MD.  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   | 23b. DATE<br>12 Apr. 82   | 23c. NAME OF CEMETERY OR CREMATORY<br>Glen Haven Mem. Pk.  | 23d. LOCATION<br>CITY OR TOWN COUNTY<br>Glen Burnie, A.A., MD.  |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>Singleton Funeral Home</u>  |   | ADDRESS<br>Glen Burnie, MD.  | 25a. DATE REC'D. BY REGISTRAR<br>APR 12 1982  |
|  |   | 25b. REGISTRAR'S SIGNATURE<br><u>Frances Jean Nathan</u>   |   |

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APR 18 1965

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 easy to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 5 8 1

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>NETTIE E. JOHNSON DORMAN</b>  |  |  |  | 2a. DATE OF DEATH<br>MONTH <b>APRIL</b> DAY <b>4</b> YEAR <b>82</b> 2b. HOUR <b>2116<sup>M</sup></b>  |  |  |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>CAUCASIAN</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>08</b> DAY <b>19</b> YEAR <b>85</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>96</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST JOSEPH HOSPITAL</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Seamstress</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Clothing</b>   |  |
| 13a. STATE<br><b>MD</b>  |  | 13b. COUNTY<br><b>BALTIMORE</b>  |  | 13c. CITY OR TOWN<br><b>TOWSON</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST <b>William</b> MIDDLE <b>H.</b> LAST <b>Johnson</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Laura</b> MIDDLE <b>Chaney</b> LAST <b>Chaney</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>212 32 3569</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Virginia Mahon, Balto., Md.</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF, (b) <b>ARREST</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <b>DIABETIC KETOACIDOSIS</b> |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>2507</b>   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22. I certify that (this hospital) attended the deceased from <b>4/4</b> 19 <b>82</b> to <b>4/4</b> 19 <b>82</b> , that (we) last saw the deceased alive on <b>4/4</b> 19 <b>82</b> , and that in (my) opinion death occurred on the date and hour and from the causes stated above (we) did (we) saw the body after death.                      |  |  |  |   |  |  |  |
| 22a. SIGNATURE<br><b>Dr. Richard Biggs, M.D.</b>   |  |  |  | DEGREE<br><b>Dr. Richard Biggs, M.D.</b>  |  | 22c. DATE SIGNED<br><b>4-4-82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Richard Biggs, M.D.</b>  |  |  |  | 22e. ADDRESS<br><b>St. Joseph's Hospital, Towson, Md.</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>4/7/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. County, Md.</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Henry W. Jenkins &amp; Sons Co.</b><br>ADDRESS <b>4905 York Road Balto., Md. 21212</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>APR 6 1982</b> 25b. REGISTRAR'S SIGNATURE<br><b>James J. [Signature]</b>   |  |  |  |

MEDICAL CERTIFICATION

1881

1881

FEMALE  
BALTIMORE

ST. JOSEPH HOSPITAL  
BALTIMORE

John on  
H. John on  
Virginia, Maryland, D.C.

1881

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1881

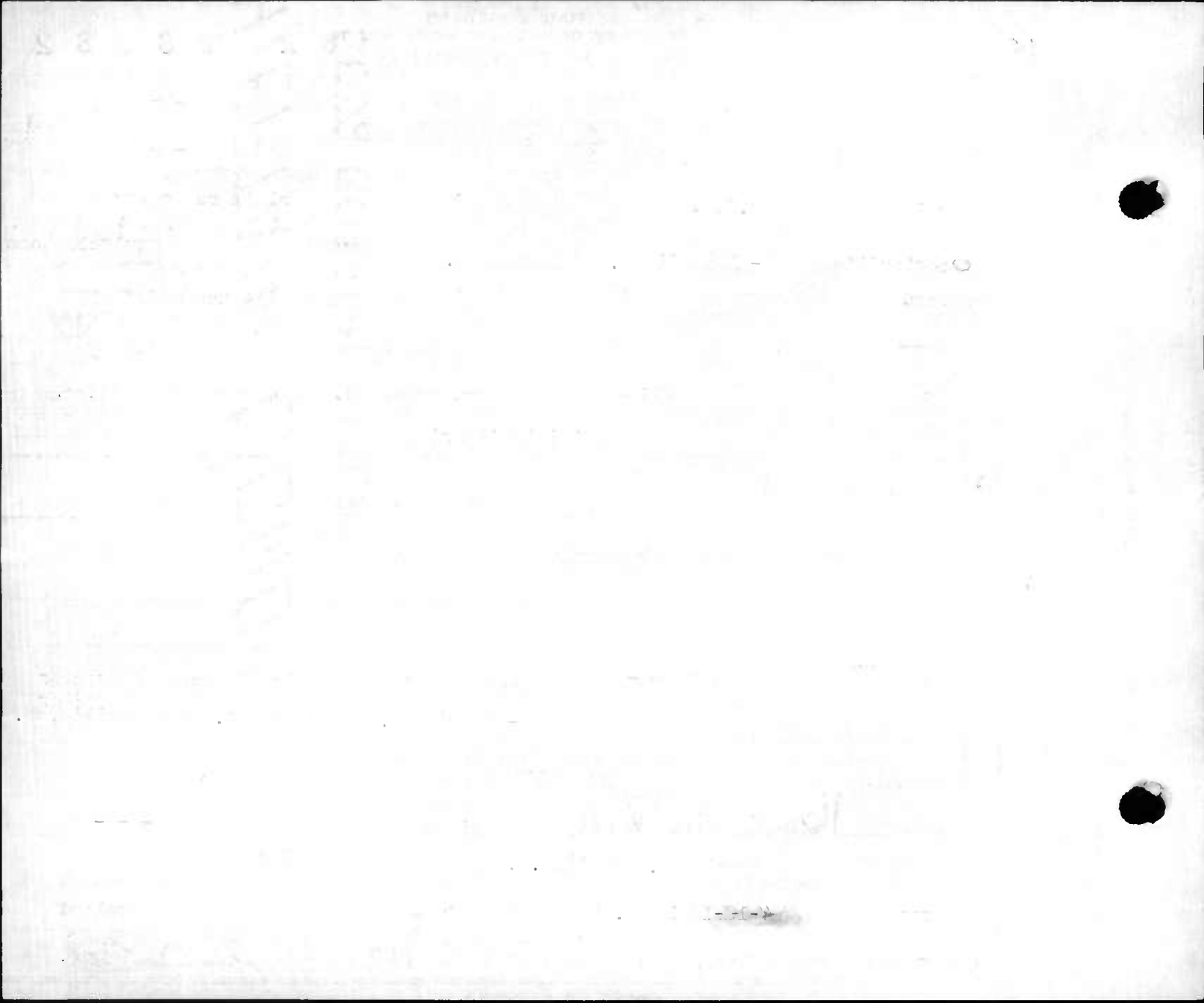
1881

1881

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                                 |  |   |  |  |  |   |  | REG. NO. 8 2 0 8 5 8 2  |  |
|--|--|---------------------------------|--|---|--|--|--|---|--|---|--|
| 1- FOR STATE REGISTRAR   |  |                                 |  |   |  |  |  |   |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>PATRICK THOMAS DOUGHERTY</b>  |  |                                 |  |   |  |  |  |   |  | 20. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 4-7-82 19 |  |
| 3. SEX<br><b>male</b>  |  | 4. RACE<br><b>white</b>         |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>Jan. 16, 1956</b>   |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY 26 YRS.   |  | IF UNDER 1 YR. MONTHS DAYS HOURS MIN.   |  | 21. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR 4-7-82 19  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  |                                 |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b>                                   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Cockeysville</b>   |  |                                 |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1-83 1/2 mile N. of Shawan Rd.</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Lineman</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>C&amp;P Telephone</b>                                     |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b> |  | 13c. CITY OR TOWN<br><b>Baldwin</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>13701 Alliston Drive</b>  |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Robert J. Dougherty</b>   |  |                                 |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Paulena R. Peters</b>   |  |  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>   |  |                                 |  | 16b. SOCIAL SECURITY NO.<br><b>217-64-4091</b>  |  | 17. INFORMANT ADDRESS<br><b>Mr. Robert J. Dougherty 13701 Alliston Dr</b>  |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY: <b>Multiple injuries</b>  |  |                                 |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| IMMEDIATE CAUSE (a) <b>8/121</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |  |                                 |  |   |  |  |  |   |  |   |  |
| (b) <b>7</b><br>DUE TO, OR AS A CONSEQUENCE OF   |  |                                 |  |   |  |  |  |   |  |   |  |
| (c) <b>2</b><br>DUE TO, OR AS A CONSEQUENCE OF   |  |                                 |  |   |  |  |  |   |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                                 |  |   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |                                 |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>               |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                                 |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>10:30 4-7-82 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>passenger in auto which impacted a tractor trailer</b> |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK  |  |                                 |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>highway</b>   |  | 21f. LOCATION<br>STREET CITY OR TOWN STATE<br><b>1-83 1/2 mile N. of Shawan Rd. Cockeysville, Md.</b>                                      |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                                 |  |   |  |  |  |   |  |   |  |
| ACTUAL SIGNATURE<br><b>Margarita A. Korell</b>   |  |                                 |  | TITLE (SPECIFY)<br><b>Assistant</b>   |  |  |  | MEDICAL EXAMINER<br><b>111 Penn Street</b>  |  |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Margarita A. Korell, M.D.</b>   |  |                                 |  | ADDRESS<br><b>111 Penn Street</b>   |  |  |  | DATE SIGNED<br><b>4-8-82</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |                                 |  | 23b. DATE<br><b>4-10-1982</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. John's Long Green</b>   |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Hydes Maryland</b>                               |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Ruck Towson Funeral Home, Inc. Towson, Maryland</b>   |  |                                 |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 12 1982</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>James J. [Signature]</b>   |  |   |  |





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 5 8 3

REG. NO.

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | 2a. DATE OF DEATH  |  | 2b. HOUR  |  |
| I. DECEASED NAME<br>(TYPE OR PRINT)  |  | 3. SEX   |  | 4. RACE   |  |
| Elizabeth J. Doyle   |  | Female   |  | White   |  |
| 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  |
| MONTH DAY YEAR<br>12 13 91   |  | 90 YRS   |  | U.S.A.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |
| Md.  |  |  |  | Balto. County MD.   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                 |  |
| Balto. County  |  | 8805 Harford Road  |  | Hairdresser   |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  |
| Md.  |  | Balto.   |  | Balto. County   |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| FIRST MIDDLE LAST<br>Steven J. Lauer   |  | FIRST MIDDLE LAST<br>Suzanna McCuvvin  |  | Self-employed   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS   |  |
| No   |  | 705-10-6001  |  | Ms. Dorothy Woodland Balto. County, Md.                                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Arteriosclerotic Coronary Artery Disease</i><br>4149<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                                     |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><i>Diabetes</i>   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?   |  |
|  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |
| 22a. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <u>June</u> , 19 <u>78</u> , to <u>4-2</u> , 19 <u>82</u> , that (I) ( <del>we</del> ) last saw the deceased alive on <u>3-20</u> , 19 <u>82</u> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death. |  | 22b. SIGNATURE<br><i>Marin C. Kowalewski MD</i>  |  | 22c. DATE SIGNED<br><u>4-30-82</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                     |  |
| M.C. KOWALEWSKI  |  | 8604 HARFORD RD  |  | Removal   |  |
| 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                                    |  |
| 4/2/82   |  |  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |
| Anatomy Board  |  | MAY 4 1982   |  | <i>[Signature]</i>  |  |
| ADDRESS  |  | 25c. REGISTRAR'S SIGNATURE   |  |   |  |
| Balto., Md.  |  |  |  |   |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

1881 25

THE UNIVERSITY OF CHICAGO  
LIBRARY

*[Faint, illegible text, likely bleed-through from the reverse side of the page]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH - 16 50M 1/B1  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |         |                              |   |  |   |  |  |  | 8 2 0 8 5 8 4   |  |  |  |                  |  |  |
|---|--|---------|------------------------------|---|--|---|--|--|--|---|--|--|--|------------------|--|--|
| 1 - FOR STATE REGISTRAR   |  |         |                              |   |  |   |  |  |  | REG. NO.  |  |  |  |                  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |         |                              |   | FIRST MIDDLE LAST  |   |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR   |  |  |  | 2b. HOUR<br>MIN. |  |  |
| JAMES W DOYLE   |  |         |                              |   |  |   |  |  |  | 4 - 6 - 82  |  |  |  | 1248P            |  |  |
| 3. SEX  |  | 4. RACE |                              | 5. DATE OF BIRTH<br>MONTH DAY YEAR  |  | 6. AGE<br>(IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                   |  | IF UNDER 24 HRS<br>HOURS MIN.   |  |  |  |                  |  |  |
| m   |  | W       |                              | 1 14 82   |  | 73 YRS.   |  |  |  |   |  |  |  |                  |  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)  |  |         | 7b. CITIZEN OF WHAT COUNTRY? |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALT. COUNTY MD. |   |  |  |  |                  |  |  |
| USA-BALTO.  |  |         | USA                          |   |  |   |  |  |  |   |  |  |  |                  |  |  |
| 10. CITY OR TOWN OF DEATH   |  |         |                              | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |                  |  |  |
| ROSEDALE  |  |         |                              | FRANKLIN SQUARE   |  |   |  | RETIRED  |  |   |  | CAN  |  |                  |  |  |
| 13a. STATE  |  |         |                              |   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS  |  |                  |  |  |
| MD  |  |         |                              |   |  | BALT  |  | BALTO.   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                             |  | 1 EASTERN AVE  |  |                  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |  |         |                              |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST  |   |  |  |  |   |  |  |  |                  |  |  |
| JAMES E. DOYLE  |  |         |                              |   | NELLIE TERRY   |   |  |  |  |   |  |  |  |                  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)  |  |         |                              |   | 16b. SOCIAL SECURITY NO.   |   |  |  |  | 17. INFORMANT ADDRESS   |  |  |  |                  |  |  |
| UNK   |  |         |                              |   | 21318-1779   |   |  |  |  | SISTER - ANNA GERBER 8180 DELHAVEN  |  |  |  |                  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardiac failure-aseptole</u><br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>cardiogenic shock;</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>acute MI-S/PC-Parrest</u> |  |         |                              |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>4/6/82  |  |  |  |                  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br>old MI, (2) CVA, ASCVD  |  |         |                              |   |  |   |  |  |  |   |  |  |  |                  |  |  |
| 19a. DATE OF OPERATION  |  |         |                              |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |         |                              |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |  |  |                  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |         |                              |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |                  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/6</u> , 19 <u>82</u> , to <u>4/6</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>4/6</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.   |  |         |                              |   |  |   |  |  |  |   |  |  |  |                  |  |  |
| 22b. SIGNATURE<br>Kathryn Yamamoto  |  |         |                              |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |  |  |  | 22c. DATE SIGNED<br>4/6/82  |  |  |  |                  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>KATHRYN YAMAMOTO   |  |         |                              |   | 22e. ADDRESS<br>9000 FRANKLIN SQ DRIVE   |   |  |  |  |   |  |  |  |                  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  |         |                              |   | 23b. DATE<br>4/9/82  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>OAK LAWN |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO. MD.  |  |  |  |                  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>J.G. CONNELLY 300 MACE  |  |         |                              |   |  |   |  |  |  | 25. DATE REC'D. BY REGISTRAR<br>APR 13 1982   |  |  |  |                  | 25. REGISTRAR'S SIGNATURE<br>Thom J. [Signature] |  |

MEDICAL CERTIFICATION

0000 BP

800-678-1915

1991 11 19

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 8 2 0 8 5 8 5   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  |  |  | REG. NO.  |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>RUTH J. DRURY</b>   |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>04 22 82</b>  |  | 2b. HOUR<br><b>2:30 AM</b>  |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>MAY 28 1896</b><br><b>X XX XX</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS MONTHS DAYS<br><b>85</b>   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>               |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY MD.</b>   |  |
| 10. TOWN OR CITY OF DEATH<br><b>KKXXK., MD.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST. JOSEPH</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Pressman</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Printer</b>   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE 13b. COUNTY<br><b>Maryland</b> <b>Baltimore</b>   |  |  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                       |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Harry C. Basil</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Alice King</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>212-07-0922D</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Mildred G. Leard, 2906 Kildaire Dr.</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>4280</b> IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>immediate</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Congestive heart failure - recurrent</b> <b>2 hours</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M.</b> <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) did (did not) re-view the body after death.   |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>A.F. DeLoskey</b>   |  |  |  | DEGREE<br><b>ATTENDING PHYSICIAN</b> <input type="checkbox"/> <b>MEDICAL DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYSICIAN</b> <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>4/22/82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>A.F. DeLoskey</b>  |  |  |  | 22e. ADDRESS<br><b>St. Joseph's Emergency Room</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>Apr. 26, 1982</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardens of Faith Overlea</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. Md.</b>   |  |
| 24. FUNERAL DIRECTOR<br><b>ROBERT C. ALTENBURG FUNERAL HOME, INC.</b><br><b>6009 Harford Rd., Balto., Md. 21214</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>APR 23 1982</b> <b>James San Antonio</b>   |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certification completed.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 5 8 6

REG. NO.

|  |   |   |  |   |  |
|--|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>WILLIAM J. DUKER</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 21, 1982</b>                     |   | 2b. HOUR<br>M  |
| 3. SEX<br><b>M</b>   | 4. RACE<br><b>W</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Sept. 12, 1913</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS HOURS MIN.<br><b>68</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore Co., MD.</b>             |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Joseph Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Supt.</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Steel</b>                                  |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Md.</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Baltimore</b> 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS <b>Apt. 6B Revere Ct.</b>  |   |   |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William J. Duker</b>  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Jeanette Schaffer</b>        |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>215 07 0810</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Cynthia Tyler Glen Burnie, Md.</b>        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrest</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>myocardial infarction</b><br>(c) <b>long standing heart dis</b> |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>minutes</b><br><b>10-12 yr.</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |   |   |  |   |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>     |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8/19/78</b> to <b>4/21/82</b> , that (I) (we) lost<br>saw the deceased alive on <b>4/21/82</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |   |   |  |   |  |
| 22b. SIGNATURE<br><b>George C. Roveti</b>  |   | DEGREE<br><b>M.D.</b>   |  | 22c. DATE SIGNED<br><b>4-23-82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>George C. Roveti, M.D.</b>   |   | 22e. ADDRESS<br><b>100 N. Broadway Baltimore, Md. 21231</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>   |   | 23b. DATE<br><b>4/23/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Green Mount Cem.</b>                 |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md.</b>  |   | 23e. REG'D BY REGISTRAR 23f. REGISTRAR'S SIGNATURE<br><b>APR 21 1982</b>  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>MITCHELL-WIEDEFELD HOME, INC. 6500 York Rd.</b>   |   |   |  |   |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 2 0 8 5 8 7  
CERTIFICATE OF DEATH

|   |  |  |  |                        |                  |
|---|--|--|--|------------------------|------------------|
| 1. FOR STATE REGISTRAR  |  | 2a. DATE OF DEATH  |  | 2b. HOUR               |                  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | MONTH DAY YEAR   |  | HOUR MIN.              |                  |
| THELMA E. DUNWORTH  |  | 4-18-82  |  | 8:12 PM                |                  |
| 3. SEX  | 4. RACE  | 5. DATE OF BIRTH   | 6. AGE (IN YEARS LAST BIRTHDAY)  | IF UNDER 1 YEAR        |                  |
| Female  | Caucasian  | October 3, 1920  | 61   | MONTHS DAYS HOURS MIN. |                  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH   |                        |                  |
| Pennsylvania  | U.S.A.   |  | Baltimore County, MD.  |                        |                  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  | 12b. KIND OF BUSINESS OR INDUSTRY  |                        |                  |
| Randallstown  | Baltimore County General Hospital  | Clerk Trainer  | U.S. Gov't.  |                        |                  |
| 13a. STATE  | 13b. COUNTY  | 13c. CITY OR TOWN  | 13d. INSIDE CITY LIMITS?   | 13e. STREET ADDRESS    |                  |
| Maryland  | Baltimore  | Woodlawn   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 1914 Gwynn Oak Avenue  |                  |
| 14. FATHER'S NAME   | 15. MOTHER'S MAIDEN NAME   | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR DATES)   |  |                        |                  |
| Ralph Dunworth  | Margaret C. Trowell  | Yes WW II 211-12-7738  |  |                        |                  |
| 17. INFORMANT   |  | ADDRESS  |  |                        |                  |
| Margaret C. Dunworth  |  | 1914 Gwynn Oak Ave   |  |                        |                  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:   |  |  |  |                        |                  |
| IMMEDIATE CAUSE (a) SEPTIC SHOCK  |  |  |  |                        |                  |
| DUE TO, OR AS A CONSEQUENCE OF (b) PNEUMONIA  |  |  |  |                        |                  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |  |                        |                  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: MYOCARDIAL INFARCTION; UNCONTROLLED DIABETIS MELLITUS  |  |  |  |                        |                  |
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20a. AUTOPSY?  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?   |                        |                  |
|   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   | YES <input type="checkbox"/> NO <input type="checkbox"/>   |                        |                  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |                        |                  |
|   | HOUR A.M. MONTH DAY YEAR P.M. 19   |  |  |                        |                  |
| 21d. INJURY OCCURRED  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    | 21f. LOCATION  |  |                        |                  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | STREET CITY OR TOWN COUNTY STATE   |  |                        |                  |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-17-82 to 4-18-82, that (I) (we) lost saw the deceased alive on 4-18-82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |                        |                  |
| 22b. SIGNATURE  |  | DEGREE   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                        | 22c. DATE SIGNED |
| ORLANDO B. CONNAN MD.   |  |  |  |                        | 4-18-82          |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |                        |                  |
| ORLANDO B. CONNAN MD.   |  | BCGH - RANDALLSTOWN MD. 21133  |  |                        |                  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   | 23b. DATE  | 23c. NAME OF CEMETERY OR CREMATORY   | 23d. LOCATION  |                        |                  |
| Burial  | 4/22/82  | Lorraine Park Cemetery   | CITY OR TOWN COUNTY STATE  |                        |                  |
|   |  | Woodlawn, Baltimore, Md.   |  |                        |                  |
| 24. FUNERAL DIRECTOR NAME   |  | 25a. DATE REC'D. BY REGISTRAR  | 25b. REGISTRAR'S SIGNATURE   |                        |                  |
| WOODLAWN MEMORIAL FH  |  | APR 28 1982  | Thom J. J. J.  |                        |                  |
| 6411 Windsor Mill Rd  |  |  |  |                        |                  |

1828

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or

| 1. FOR STATE REGISTRAR   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  | 8 2 0 8 5 8 8   |  | REG. NO.  |  |
|--|--|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>James Walter Dushane   |  |  |  | 2a. DATE OF DEATH<br>4 27 82  |  | 2b. HOUR<br>11:20A <sub>M</sub>   |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>Aug 17, 1905  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>76   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>Towson  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Greater Baltimore Medical Center |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Accountant   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Accounting   |  |
| 13a. STATE<br>Md.  |  | 13b. COUNTY<br>Balto.  |  | 13c. CITY OR TOWN<br>Lutherville  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                       |  |
| 14. FATHER'S NAME<br>James Henry Dushane   |  | 15. MOTHER'S MAIDEN NAME<br>Estelle Walter   |  | 16. SOCIAL SECURITY NO.<br>218-12-2531  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>---  |  | 17. INFORMANT ADDRESS<br>Mrs. Catherine G. Dushane, 12 Nightingale  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Diffuse malignant lymphoma</u><br>2082<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |  |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Feb 17</u> , 19 <u>82</u> , to <u>Apr 27</u> , 19 <u>82</u> , that (I) (we) lost<br>saw the deceased alive on <u>Apr 27</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |
| 22b. SIGNATURE OF PHYSICIAN<br><u>Chm e. Brown</u>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br>4-27-82   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Charles C. Brown, M.D.  |  |  |  | 22e. ADDRESS<br>6701 N. Charles St. Towson, MD 21204  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation   |  | 23b. DATE<br>4/30/82   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Westview Crematory  |  | 23d. LOCATION<br>Baltimore Maryland   |  |
| 24. FUNERAL DIRECTOR<br>Lemmon-Mitchell-Wiedefeld  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 3 1982   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Francis Jean Warkner</u>   |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 5 8 9

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |   |   |  |                                |  |
|--|--|---|---|--|--------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Edwin H EARDLEY</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 29, 1982</b>            |  | 2b. HOUR<br><b>1:00p</b>       |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Cauc. ,</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Nov. 24, 1901</b>                     |                                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Baltimore, Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b><br>YRS. MONTHS DAYS HRS. MIN.     |                                |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Square Hosp.</b> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b><br>MD.         |                                |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Pressman</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Sun Papers</b>  |   |  |                                |  |
| 13a. STATE<br><b>Md.</b>   |  |   | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>--</b> |  |
| 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   | 13e. STREET ADDRESS<br><b>Baltimore, Md. 6733 Roberts Ave, 21222</b>    |  |                                |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William A. Eardley</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Elizabeth Smith</b> |  |                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No --</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>213-03-2722</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Ethel M. Eardley, same as above</b>             |                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest, Chronic Obstructive</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Pulmonary Disease, Congestive Heart Failure,</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <b>Pneumonia</b> |  |   |   |  |                                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |   |  |                                |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |                                |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                |  |
| 22a. I certify that (X) this hospital attended the deceased from <b>April 16</b> , 19 <b>82</b> , to <b>April 29</b> , 19 <b>82</b> , that (X) (we) last saw the deceased alive on <b>April 29</b> , 19 <b>82</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (do) not view the body after death.                                  |  |   |   |  |                                |  |
| 22b. SIGNATURE<br><b>Robert L. Lyles</b>   |  |   |   | 22c. DATE SIGNED<br><b>4-29-82</b>   |                                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Robert L. Lyles, M.D.</b>  |  |   |   | 22e. ADDRESS<br><b>9000 Franklin Square Dr. Balto., MD 21237</b>               |                                |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>May 3, 1982</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oaklawn Cem.</b>                      |                                |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 30 1982</b>   |   |  |                                |  |
| 24. FUNERAL DIRECTOR'S NAME<br><b>Schimunek Funeral Home, 3331 Brehms Lane, 21213</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Thane Jan Mast...</b>  |   |  |                                |  |

MEDICAL CERTIFICATION

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the body of the deceased with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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080000

APR 30 1960

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |  |  | 8 2 0 8 5 9 0  |  |  |  |
|--|--|--|--|---|--|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  |   |  |   |  |  |  | REG. NO.   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>William Henry EAST</b>  |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 6, 1982</b>                           |  |  |  | 2b. HOUR<br><b>9:10 PM</b>   |  |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Dec. 15, 1901</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b> YRS.                                     |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS<br>HOURS MIN.  |  |  |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                   |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rosedale</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Square Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Supervisor</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Railroad</b>   |  |  |  |  |  |
| 13a. STATE<br><b>Maryland</b>  |  |  |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Perry Hall</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>7 Thurmont Ct.</b>   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William East</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Emma Ullrich</b>  |  |   |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>705-05-2068</b>  |  | 17. INFORMANT<br><b>Mrs. Esther W. East</b>   |  |  |  | ADDRESS<br><b>Same</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiorespiratory arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Decompensated congestive heart failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)<br><b>sideroblastic anemia</b>  |  |  |  |   |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)         |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                     |  |  |  |  |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>April 1</b> , 19 <b>82</b> , to <b>April 6</b> , 19 <b>82</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>April 6</b> , 19 <b>82</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><i>Robert Rose</i> MD  |  |  |  |   |  | DEGREE<br><b>MD</b>   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>4/6/82</b>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Robert Rose MD</b>   |  |  |  |   |  | 22e. ADDRESS<br><b>9000 Franklin Square Dr., 21237</b>                                |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |  |  | 23b. DATE<br><b>April 9, 1982</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley</b>                           |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Cockeysville, Balto. Co., Md.</b>   |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212</b>   |  |  |  | ADDRESS<br><b>6500 York Rd.</b>   |  | 25a. DATE OF DEATH BY REGISTRAR<br><b>APR 12 1982</b>                                 |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |  |  |  |  |

0 8 2 9 0

RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE  
WASHINGTON, D. C.

TO : SAC, NEW YORK (100-100000) FROM : SAC, NEW YORK (100-100000)

SUBJECT: [Illegible] DATE: 10/10/50

RE: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

15. [Illegible]



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 5 9 1

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |   |   |  |   |   |  |   |                                    |  |
|---|--|--|---|---|--|---|---|--|---|------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Harry M. EDWARDS</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 11, 1982</b>              |   |  | 2b. HOUR<br><b>2:10a M</b>  |   |  |   |                                    |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Cau.</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 24 97</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>84</b> YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |   |                                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                                 |   |  |   |                                    |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Square Hospital</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Security Guard Pinkerton</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY  |   |                                    |  |
| 13a. STATE<br><b>Md.</b>  |  |  | 13b. COUNTY<br><b>-</b>   |   | 13c. CITY OR TOWN<br><b>Balto.</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>3022 Gilford Ave.</b> |                                    |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Ralph C. Edwards</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Harriett Topscott</b> |   |  |   |   |  |   |                                    |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>no</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>214-30-2600</b>                            |   | 17. INFORMANT<br>ADDRESS<br><b>6801 Sallie L. Schaumloeffel Gunder Ave.</b>    |   |   |  |   |                                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory arrest</b><br><b>5070</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Probable aspiration pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Septic shock</b>  |  |  |   |   |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH    |                                    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |   |   |  |   |   |  |   |                                    |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                          |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |   |                                    |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |   |  |   |                                    |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)     |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |   |  |   |                                    |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>April 5</b> , 19 <b>82</b> , to <b>April 11</b> , 19 <b>82</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>April 11</b> , 19 <b>82</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input type="checkbox"/> (we) (did) (did not) view the body after death. |  |  |   |   |  |   |   |  |   |                                    |  |
| 22b. SIGNATURE<br><b>Steven B. Snyder, M.D.</b>   |  |  |   |   |  | DEGREE<br><b>PHYSICIAN</b>  |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>4/11/82</b> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Steven B. Snyder, M.D.</b>  |  |  |   |   |  | 22e. ADDRESS<br><b>9000 Franklin Square Drive 21237</b>   |   |  |   |                                    |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>4-14-82</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Balto. Cem.</b>                       |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. Md.</b>                                 |  |   |                                    |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>John C. Miller Inc. 6415 Belair Rd.</b>  |  |  |   |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 13 1982</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>James J. Nathan</b>   |   |                                    |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1908

RECEIVED  
JAN 10 1908

TO THE  
HONORABLE  
SIR  
THE SECRETARY  
OF THE  
NAVY  
WHITE HALL  
LONDON  
SIR  
I HAVE THE HONOR TO  
ACKNOWLEDGE THE RECEIPT  
OF YOUR LETTER OF THE  
10TH INSTANT IN WHICH  
YOU REQUESTED THAT I  
SHOULD BE GOOD ENOUGH  
TO FORWARD TO YOU  
A COPY OF THE  
REPORT OF THE  
COMMISSIONER OF THE  
NAVY  
IN RESPONSE TO  
YOUR LETTER OF THE  
10TH INSTANT  
I HAVE THE HONOR TO  
STATE THAT THE  
REPORT OF THE  
COMMISSIONER OF THE  
NAVY IS NOW  
BEING FORWARDED TO  
YOU BY THE  
POST OF THE  
12TH INSTANT  
I AM, SIR,  
YOUR OBLIGED  
SERVANT  
J. H. B. [Signature]

THE SECRETARY  
OF THE  
NAVY  
WHITE HALL  
LONDON  
SIR  
I HAVE THE HONOR TO  
ACKNOWLEDGE THE RECEIPT  
OF YOUR LETTER OF THE  
10TH INSTANT IN WHICH  
YOU REQUESTED THAT I  
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J. H. B. [Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |   |  |  |  |  |   | 8 2 0 8 5 9 2  |  |  |  |
|---|--|---|--|---|--|--|--|--|---|--|--|--|--|
| 1 - FOR STATE REGISTRAR   |  |   |  |   |  |  |  |  |   | REG. NO.   |  |  |  |
| 1. DECEASED NAME<br>(TYPE NAME)<br>FIRST MIDDLE LAST<br><i>Frederick E. Elliott</i>   |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>4-27-82</i>                |  |  |  | 2b. HOUR<br><i>5:05 PM</i>  |  |  |  |  |
| 3. SEX<br><i>male</i>   |  | 4. RACE<br><i>White</i>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>9 11 09</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>72</i> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |   | IF UNDER 24 HRS.   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Virginia</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore County</i> MD.  |  |  |   |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Randallstown</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Baltimore County General Hospital</i> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Oil Burner Service</i>  |  |  |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| 13a. STATE<br><i>Maryland</i>   |  | 13b. COUNTY<br><i>Baltimore</i>   |  | 13c. CITY OR TOWN<br><i>Owings Mills</i>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS<br><i>141 South Ritters Lane</i>                                 |   |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Joseph Elliott</i>   |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Sarah Varney</i> |  |  |  |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i>   |  |   |  |   | 16b. SOCIAL SECURITY NO.<br><i>215-07-3220</i>                       |  | 17. INFORMANT<br><i>Mrs. Edith Elliott</i> <i>21133</i><br><i>141 South Ritters Lane Owings Mills, MD.</i> |  |   |  |  |  |  |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cardio pulmonary arrest 2° to</i><br><i>4140</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <i>ASHD with severe pul. edema</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>COPD, Hyperkalemic</i> |  |   |  |   |  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br><i>probably Aortic stenosis and questionable pulmonary emboli</i>   |  |   |  |   |  |  |  |  |   |  |  |  |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <i>19</i>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>4-26-82</i> 19 <i>82</i> to <i>4-27-82</i> 19 <i>82</i> that (I) (we) lost saw the deceased alive on <i>4-27-82</i> 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |  |  |   |  |  |  |  |
| 22b. SIGNATURE<br><i>R-m. Shah</i>  |  |   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  | 22c. DATE SIGNED<br><i>4-27-82</i>  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>R-M. SHAH.</i>  |  |   |  |   |  | 22e. ADDRESS<br><i>B.C.G.H. old court RD &amp; living RD, RANDALLSTOWN</i>   |  |  |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>  |  |   |  | 23b. DATE<br><i>4-30-82</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Moreland Mem. Park</i>  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Parkville Baltimore Maryland</i> |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <i>Boring Byers Funeral Directors, Inc.</i><br>ADDRESS <i>8728 Liberty Road Randallstown, MD. 21133</i>  |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><i>APR 29 1982</i>  |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>James Van Natten</i>                             |  |  |  |  |

5 4 3 2 1

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*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page.]*



*[Faint, mostly illegible handwritten text at the bottom of the page.]*

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 5 9 3

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |  |   |  |   |                                  |   |  |
|---|--|---|--|---|----------------------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>JULIA A. ELLISON</b> |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 21, 1982</b> |   | 2b. HOUR<br>P M<br><b>6:50 P</b> |   |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Sept. 24, 1908</b>   |                                  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS<br><b>73</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                        |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.                             |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST. JOSEPH HOSPITAL</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>  |                                  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Towson</b>  |                                  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Leo A. Goodwin</b>                     |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Teresa Wills</b>   |  | 13e. STREET ADDRESS<br><b>1000 E. Joppa Road</b>  |                                  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES NO OR UNKNOWN)<br><b>NO</b>    |  | 16b. SOCIAL SECURITY NO.<br><b>218-05-9419</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>James H. Ellison, Sr., Same As #13e</b>  |                                  |   |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY  
IMMEDIATE CAUSE (a) **ACUTE MYOCARDIAL INFARCTION**

4100  
Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 11a

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>JAN. 28, 1982</b> to <b>APRIL 21, 1982</b> , that (we) lost<br>saw the deceased <b>die on April 21, 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><i>Beatriz P. Dizon, M.D.</i>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>Apr. 21, 1982</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BEATRIZ P DIZON</b>  |  |  |  | 22e. ADDRESS<br><b>7620 YORK RD TOWSON, MD. 21204</b>  |  |   |  |

|   |  |                             |  |   |  |  |  |
|---|--|-----------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                   |  | 23b. DATE<br><b>4-24-82</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge Cemetery</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Pikesville, Balto. Maryland</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Ruck Towson Funeral Home, Inc. Towson, Md. 21204</b> |  |                             |  | 25a. DATE REC'D BY REGISTRAR<br><b>APR 23 1982</b>                |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles J. Nathan</i>                           |  |

6 8 8 1 2 8

UNIVERSITY OF CALIFORNIA

UNIVERSITY OF CALIFORNIA

UNIVERSITY OF CALIFORNIA

UNIVERSITY OF CALIFORNIA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 8 2 0 8 5 9 4<br>REG. NO.   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  |  |  | 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  |  |
| John Leroy Elmos  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>April 14, 1982   |  |  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Dec. 7, 1921  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>60 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD  |  |
| 10. CITY OR TOWN OF DEATH<br>Essex  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>920 Arnccliffe Road                     |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Sheet Metal Mech.   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Sheet Metal Fabricating   |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>Essex  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>George N. Elmos   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mabel L. Hughes   |  | 13e. STREET ADDRESS<br>920 Arnccliffe Road 21221  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WWII 070 18 7788  |  | 17. INFORMANT<br>Natalie Elmos  |  | ADDRESS<br>Same  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Metastatic Gastric Carcinoma</i><br>1519<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (1) this hospital attended the deceased from <i>January 2-25</i> 19 <i>82</i> , to <i>present</i> 19 <i>82</i> , and that (2) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (I) (did not) view the body after death.  |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><i>Dr. R. Penel-Mera</i>  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>4-14-82   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>5400 OLD COURT ROAD  |  | 22e. ADDRESS<br>RANDALLSTOWN Md 21133  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>4-17-82   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Holly Hill Mem. Gardens   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore County, Maryland   |  |
| 24. FUNERAL DIRECTOR<br><i>Brudzinski Funeral Home</i>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>APR 16 1982  |  | 25b. REGISTRAR'S SIGNATURE<br><i>James J. Nathan</i>   |  |

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April 10 1965

John F. Kennedy

to

Mr. J. F. Kennedy

Dear Mr. Kennedy:

I am writing to you

to express my appreciation

for the information

you have provided

regarding the

history of the

document.

I am sure that

you will find this

very

interesting and

valuable.

Sincerely,

John F. Kennedy

APR 16 1965



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified to make an autopsy.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 5 9 5

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  | 2a. DATE OF DEATH  |  | 2b. HOUR  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | 2a. DATE OF DEATH  |  | 2b. HOUR  |  |
| AUGUSTA M. ELSEROAD  |  | 04 27 82   |  | 4:38 A.M.   |  |
| 3. SEX   | 4. RACE  | 5. DATE OF BIRTH   | 6. AGE (IN YEARS LAST BIRTHDAY)  | IF UNDER 1 YEAR   |  |
| FEMALE   | WHITE  | MONTH DAY YEAR<br>07 13 91   | 90 YRS.  | MONTHS  | DAYS   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH   |   |  |
| MARYLAND   | U.S.A.   |  | BALTIMORE COUNTY MD.   |   |  |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  | 12b. KIND OF BUSINESS OR INDUSTRY  |   |  |
| CATONSVILLE  | FREDERICK VILLA NURSING CENTER   | HOUSEWIFE  | ---  |   |  |
| 13a. STATE   | 13b. COUNTY  | 13c. CITY OR TOWN  | 13d. INSIDE CITY LIMITS?   | 13e. STREET ADDRESS                                     |  |
| MARYLAND   | ---  | BALTIMORE  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  | 1243 CARROLL STREET, 21230                              |  |
| 14. FATHER'S NAME  | 15. MOTHER'S MAIDEN NAME   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |   |  |
| AUGUST KUMMER  | IDA J. ESHELMAN  | NO   |  |   |  |
| 16b. SOCIAL SECURITY NO.   | 17. INFORMANT  | ADDRESS  |  |   |  |
| 215-09-3655  | STANLEY T. ELSEROAD  | 21227 1249 POPLAR AVENUE   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <i>Cardiac failure</i>   |  |  |  |   | <i>sudden</i>                                |
| 4292 DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |  |   |  |
| (b) <i>degenerative Cardio Vasc Dis</i>  |  |  |  |   | <i>slow</i>                                  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |  |
| (c) <i>acc</i>   |  |  |  |   | <i>unknown</i>                               |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Cu of Colon &amp; Rectal Colon</i>   |  |  |  |   |  |
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20a. AUTOPSY?  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?   |   |  |
|  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
|  |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
|  |  |  |  |   |  |
| 22a. I certify that (I) <del>this hospital</del> attended the deceased from <i>4/23</i> 19 <i>82</i> to <i>4/27</i> 19 <i>82</i> that (I) <del>met</del> lost saw the deceased alive on <i>4/28</i> 19 <i>82</i> and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>would not</del> (did not) view the body after death. |  |  |  |   |  |
| 22b. SIGNATURE   |  | DEGREE   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED                             |
| <i>Cliff Ratliff - M.D.</i>  |  |  |  |   | <i>4/27/82</i>                               |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |   |  |
| CLIFF RATLIFF, JR., M.D.   |  | 5772 WESTVIEW MALL, 21228  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  | 23b. DATE  | 23c. NAME OF CEMETERY OR CREMATORY   | 23d. LOCATION CITY OR TOWN COUNTY STATE  |   |  |
| BURIAL   | 04-30-82   | LOUDON PARK  | BALTIMORE CITY MARYLAND  |   |  |
| 24. FUNERAL DIRECTOR NAME  |  | 24b. ADDRESS   |  | 25a. DATE RECD. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE |  |
| HUBBARD FUNERAL HOME, INC.   |  | 4107 WILKENS AVE.  |  | APR 28 1982 <i>James J. Warden</i>                      |  |

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RECEIVED

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U.S. DEPT. OF JUSTICE

WASHINGTON, D.C.

ATTORNEY GENERAL

JOHN EDGAR HOOVER

DEPT. OF JUSTICE

WASHINGTON, D.C.

NOV 10 1950

U.S. DEPT. OF JUSTICE

WASHINGTON, D.C.

NOV 10 1950

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WASHINGTON, D.C.

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RECEIVED NOV 10 1950

U.S. DEPT. OF JUSTICE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |  |  | 8 2 0 8 5 9 6<br>REG. NO.  |  |  |  |
|---|--|---|--|---|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>GEORGE W ELSTE</b>   |  |   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4-12-82</b>   |  |  |  | 2b. HOUR<br><b>2:35pm</b>  |  |  |  |
| 3. SEX<br><b>M</b>  |  | 4. RACE<br><b>W</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Sept. 25, 1896</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>85</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY MD.</b>                             |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST. JOSEPH HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Supt. Safety</b>         |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Railroad</b>                                 |  |  |  |  |  |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Towson</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>802 Mockingbird Ln.</b>                                    |  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George W. Elste</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ida Allender</b>  |  |   |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WW I</b>  |  | 17. INFORMANT<br><b>Mrs. Virginia S. Elste</b>  |  | ADDRESS<br><b>802 Mockingbird Ln.</b>   |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). MYOCARDIAL INFARCTION<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |  |   |  |   |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |  |
| 22a. I certify that (x) (this hospital) attended the deceased from <b>3-31</b> 19 <b>82</b> to <b>4-12</b> 19 <b>82</b> , that (1) (we) lost<br>saw the deceased alive on <b>4-12</b> 19 <b>82</b> , and that in (x) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (x) (we) (did) (not) view the body after death.                                       |  |   |  |   |  |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><i>Beatriz P. Dizon, M.D.</i>   |  |   |  |   |  | DEGREE<br><b>M.D.</b>   |  | 22c. DATE SIGNED<br><b>Apr. 12, 1982</b>   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BEATRIZ P. DIZON, M.D.</b>  |  |   |  |   |  | 22e. ADDRESS<br><b>7620 YORK ROAD TOWSON, M.D. 21204</b>  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>4/15/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moreland Memorial</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md.</b>                             |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>MITCHELL-WIEDEFELD HOME, INC. 6500 York Rd.</b>  |  |   |  |   |  | 25a. DATE RECEIVED BY REGISTRAR<br><b>APR 16 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                     |  |  |  |  |  |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon portions. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 5 9 7

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |   |  |  |
|--|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Irvin - Erdman</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 27, 1982</b>  |  | 2b. HOUR<br>M  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Sept. 20, 1919</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS HOURS MIN.<br><b>62</b>          |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Md.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Glen Arm</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>11229 Notch Cliff Road</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Zone Inspector Balto. Co. Ret.</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br><b>Md.</b>   | 13b. COUNTY<br><b>Baltimore</b>  | 13c. CITY OR TOWN<br><b>Glen Arm</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           | 13e. STREET ADDRESS<br><b>11229 Notch Cliff Road</b>                                 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Irvin Erdman</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>- - -</b>   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>yes WW 2</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>214-01-6050</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Pearl Erdman Same</b>                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>respiratory failure</b><br><b>1850</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Metastatic Ca prostate 3 yrs</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>-</b><br>DUE TO, OR AS A CONSEQUENCE OF |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>no</b>   |  |   |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>JULY 19 79</b> to <b>MARCH 19 82</b> , that (I) (we) lost<br>saw the deceased above, <b>3-2</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |   |   |  |  |
| 22b. SIGNATURE<br><b>A. Schenwald MD</b>   |  |   |   | 22c. DATE SIGNED<br><b>4-2-82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>H. SCHENWALD</b>   |  |   |   | 22e. ADDRESS<br><b>660 KENIL WORTH RD, TOWSON</b>                                    |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Removal</b>   |  | 23b. DATE<br><b>3/28/82</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>-</b>                                       |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  | 23e. DATE REC'D. BY REGISTRAR<br><b>APR 12 1982</b>   |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Anatomy Board</b>   |  | ADDRESS<br><b>Balto., Md.</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>James Jan Nathan</b>                                |  |

18200 28

RECEIVED  
JAN 10 1964

18200

*[Faint, mostly illegible handwritten text across the page]*

RECEIVED  
JAN 10 1964



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |   |  |  |  |  |  | 8 2 0 8 5 9 8   |  |  |  |
|---|--|--|--|---|--|--|--|--|--|---|--|--|--|
| 1 - FOR STATE REGISTRAR   |  |  |  |   |  |  |  |  |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>ETHYL C. ESTES</b>  |  |  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>April 13, 1982</b>                                    |  |  |  | 2b. HOUR<br><b>10:30 A.M.</b>   |  |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Nov. 4, 1879</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>102</b> YRS.   |  | IF UNDER 1 YEAR MONTHS DAYS  |  | IF UNDER 24 HRS. HOURS MIN.   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                          |  |  |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Manor Care Ruxton</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Towson Balto</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS <b>111 W. Centre Street</b><br><b>7001 W. Charles Street</b> |  |   |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>A. W. Chaney</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>unknown</b>  |  |  |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br><b>217-16-3158</b>   |  | 17. INFORMANT ADDRESS<br><b>Mr. William Gering 25 S. Charles St.</b>  |  |  |  |  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of Left Breast</b><br><b>1749</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Years</b> |  |  |  |   |  |  |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a  |  |  |  |   |  |  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>           |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)               |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NO WHILE AT WORK <input type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from <b>July 1978</b> to <b>April 13, 1982</b> , that (I) (we) last saw the deceased alive on <b>April 13, 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If two (did) did not view the body after death.   |  |  |  |   |  |  |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Marc I. Leavey, M.D.</b>   |  |  |  |   |  | 22c. DATE SIGNED<br><b>13 April 82</b>   |  |  |  |   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Marc I. Leavey, M.D.</b>  |  |  |  |   |  | 22e. ADDRESS<br><b>7600 Osler Drive</b>  |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>   |  | 23b. DATE<br><b>4-16-1982</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park</b>  |  | 23d. LOCATION<br><b>Baltimore</b>  |  | COUNTY <b>Maryland</b> STATE   |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Ruck Towson Funeral Home, Inc.</b>   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 16 1982</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Thomas J. [Signature]</b>                       |  |   |  |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be returned by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |  |  |  |  |  |  | 8 2 0 8 5 9 9   |  |
|--|--|--|--|--|--|--|--|--|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  |  |  |  |  |  |  |  |  | CERTIFICATE OF DEATH  |  |
| 1. DECEASED NAME   |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH   |  |
| FIRST MIDDLE LAST  |  |  |  |  |  |  |  |  |  | MONTH DAY YEAR  |  |
| WILLIAM E.dward EUBERT   |  |  |  |  |  |  |  |  |  | April 19, 1982  |  |
| 1. SEX   |  |  |  |  |  |  |  |  |  | 2b. HOUR  |  |
| Male   |  |  |  |  |  |  |  |  |  | 10:17am   |  |
| 4. RACE  |  |  |  |  |  |  |  |  |  | 5. DATE OF BIRTH  |  |
| White  |  |  |  |  |  |  |  |  |  | MONTH DAY YEAR  |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)  |  |  |  |  |  |  |  |  |  | IF UNDER 1 YEAR   |  |
| 75   |  |  |  |  |  |  |  |  |  | MONTHS DAYS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |  |  |  |  |  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> |  |
| Balto., Md.  |  |  |  |  |  |  |  |  |  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                    |  |
| 7b. CITIZEN OF WHAT COUNTRY?   |  |  |  |  |  |  |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |
| U.S.A.   |  |  |  |  |  |  |  |  |  | Baltimore County MD.  |  |
| 10. CITY OR TOWN OF DEATH  |  |  |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                         |  |
| Rossville  |  |  |  |  |  |  |  |  |  | Printer   |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)   |  |  |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| Franklin Sq. Hosp.   |  |  |  |  |  |  |  |  |  | Oriole Print  |  |
| 13a. STATE   |  |  |  |  |  |  |  |  |  | 13b. COUNTY   |  |
| Md.  |  |  |  |  |  |  |  |  |  | Balto.  |  |
| 13c. CITY OR TOWN  |  |  |  |  |  |  |  |  |  | 13d. INSIDE CITY LIMITS?  |  |
| Parkville  |  |  |  |  |  |  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                   |  |
| 14. FATHER'S NAME  |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME  |  |
| FIRST MIDDLE LAST  |  |  |  |  |  |  |  |  |  | FIRST MIDDLE LAST   |  |
| William Henry Eubert   |  |  |  |  |  |  |  |  |  | Florence Mae Shaeffer   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO.  |  |
| no   |  |  |  |  |  |  |  |  |  | 214-01-9634-A   |  |
| 17. INFORMANT  |  |  |  |  |  |  |  |  |  | ADDRESS   |  |
| William J. Eubert,   |  |  |  |  |  |  |  |  |  | 7726 Bagley Ave. Balto., Md. 21233  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:  |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| IMMEDIATE CAUSE (a) Cardiopulmonary Arrest   |  |  |  |  |  |  |  |  |  |   |  |
| 4860   |  |  |  |  |  |  |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |  |  |   |  |
| (b) Pneumonia  |  |  |  |  |  |  |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |  |  |   |  |
| (c)  |  |  |  |  |  |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:   |  |  |  |  |  |  |  |  |  |   |  |
| History of Cardiovascular Disease  |  |  |  |  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                      |  |
| 20a. AUTOPSY?  |  |  |  |  |  |  |  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?                        |  |
| YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  |  |  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY   |  |
|  |  |  |  |  |  |  |  |  |  | HOUR A.M. MONTH DAY YEAR  |  |
|  |  |  |  |  |  |  |  |  |  | P.M. 19   |  |
| 21d. INJURY OCCURRED   |  |  |  |  |  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                   |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>  |  |  |  |  |  |  |  |  |  | 21f. LOCATION   |  |
| AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  |  |  |  |  |  |  |  | STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (this hospital) attended the deceased from April 14, 1982, to April 19, 1982, that (we) lost saw the deceased alive on April 19, 1982, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |   |  |
| 22b. SIGNATURE   |  |  |  |  |  |  |  |  |  | 22c. DATE SIGNED  |  |
| Richard DelPiero M.D.  |  |  |  |  |  |  |  |  |  | 4/19/82   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  |  |  |  |  |  |  | 22e. ADDRESS  |  |
| Richard DelPiero   |  |  |  |  |  |  |  |  |  | 9000 Franklin Square Drive 21237  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  |  |  |  |  |  |  |  | 23b. DATE   |  |
| Burial   |  |  |  |  |  |  |  |  |  | 4-22-82   |  |
| 23c. NAME OF CEMETERY OR CREMATORY   |  |  |  |  |  |  |  |  |  | 23d. LOCATION   |  |
| Parkwood Cem.  |  |  |  |  |  |  |  |  |  | CITY OR TOWN COUNTY STATE   |  |
|  |  |  |  |  |  |  |  |  |  | Parkville Balto. Md   |  |
| 24. FUNERAL DIRECTOR   |  |  |  |  |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR   |  |
| NAME ADDRESS   |  |  |  |  |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE  |  |
| Lassahn F.H. 7401 Belair Rd  |  |  |  |  |  |  |  |  |  | APR 26 1982   |  |

4 8 3 0

23

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 6 0 0

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|   |   |   |  |  |  |
|---|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>JOSEPHINE T. EVANS</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4 4 82</b>                                 |  | 2b. HOUR<br><b>2:10 PM</b>   |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 12 00</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>82</b><br>YRS. MONTHS DAYS HOURS MIN.          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County MD.</b>                  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Catonsville</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Inglennook Nursing Home</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>   |
| 13a. STATE<br><b>Md</b>   |   |   | 13b. COUNTY<br><b>Baltimore</b>  | 13c. CITY OR TOWN<br><b>Catonsville</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Howard</b>   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ella Josephine (unknown)</b>     |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>219-20-6692</b>  |  | 17. INFORMANT<br><b>Lewis R. Evans, Jr. Same as #13</b>                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4100 Atherosclerotic Cardio Vasc. Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary artery occlusion.</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Cerebral atherosclerosis</b>   |   |   |  |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4-1-82</b> to <b>4-4-82</b> , that (I) (we) last saw the deceased alive on <b>4-1-82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.   |   |   |  |  |  |
| 22b. SIGNATURE<br><b>Harry L. Knipp, M.D.</b>   |   | DEGREE<br><b>M.D.</b>   |  | 22c. DATE SIGNED<br><b>4/5/82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Harry L. Knipp, M.D.</b>  |   | 22e. ADDRESS<br><b>5411 Old Frederick Rd Suite 20 Balto.Md.</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |   | 23b. DATE<br><b>4/7/82</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cemetery</b>                    |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Witzke, P.A.</b><br><b>1600 Edmondson Ave Catonsville, Md. 21228</b>   |   |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 6 1982</b>                                   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |   |   | 8 2 0 8 6 0 1<br>REG. NO.                    |  |  |  |
|---|--|--|--|--|--|--|--|---|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Patricia L. EVANS</b>  |  |  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 17, 1982</b>   |  |   |   | 2b. HOUR<br><b>7:57 P.M.</b>                 |  |  |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>NEGRO</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>AUGUST 20 1958</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>23</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>23</b>   |   | IF UNDER 24 HRS.<br>HOURS MIN.<br><b>57</b>  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County MD.</b>  |  |   |   |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE CO</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>FRANKLIN SQUARE HOSPITAL</b> |  |  |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>STUDENT</b>                            |   | 12b. KIND OF BUSINESS OR INDUSTRY            |  |  |  |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>BALTIMORE</b>  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>115 FLEMING DRIVE 21222</b>   |   |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>WILLIAM H. EVANS</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ELIZABETH A. JOHNSON</b>   |  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b> |   |  |  |  |  |
| 16b. SOCIAL SECURITY NO.  |  |  |  | 17. INFORMANT<br><b>SC.</b>  |  |  |  | ADDRESS<br><b>WILLIAM H. EVANS/115 FLEMING DRIVE</b>  |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Right Cerebellar Glioma</b><br><b>1919</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |  |  |  |  |  |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |  |  |  |  |  |  |  |   |   |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |   |  |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>April 14, 19 82</b> to <b>April 17, 19 82</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>April 17, 19 82</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input type="checkbox"/> (we) did not view the body after death. |  |  |  |  |  |  |  |   |   |  |  |  |  |
| 22b. SIGNATURE<br><i>Matthew Scott</i>  |  |  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>4/17/82</b>  |   |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MATTHEW SCOTT MD</b>  |  |  |  |  |  | 22e. ADDRESS<br><b>9000 Franklin Square Dr., 21237</b>   |  |   |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  |  | 23b. DATE<br><b>04/23/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>EASTVIEW MEM PARK</b> |  |  | 23d. LOCATION<br><b>BALTIMORE</b> COUNTY <b>MARYLAND</b>  |   |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>MARSHALL W JONES, JR/4101 EDMONDSON AVE</b>  |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 20 1982</b>  |  |   |   |  |  |  |  |
| 25b. REGISTRAR'S SIGNATURE<br><i>James J. [Signature]</i>   |  |  |  |  |  |  |  |   |   |  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called and an autopsy performed.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 6 0 2

|  |                     |  |  |
|--|---------------------|--|--|
| 1. FOR STATE REGISTRAR   |                     | REG. NO.   |  |
| I. DECEASED NAME<br>Yiu-Kwan Fan   |                     | 2a. DATE OF DEATH<br>4 10 82   |  |
| 2b. HOUR<br>11:10 AM   |                     |  |  |
| 3. SEX<br>female   | 4. RACE<br>Oriental | 5. DATE OF BIRTH<br>Nov. 19, 1904  |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br>77  |                     | IF UNDER 1 YEAR<br>MONTHS DAYS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>China   |                     | 7b. CITIZEN OF WHAT COUNTRY?<br>China  |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |                     | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Randallstown  |                     | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Balto. County General Hospital             |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Home Maker  |                     | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>MD   |                     | 13b. COUNTY<br>Balto.  |  |
| 13c. CITY OR TOWN<br>Randallstown  |                     | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 13e. STREET ADDRESS<br>3706 D Brice Run Rd.  |                     |  |  |
| 14. FATHER'S NAME<br>Cheung  |                     | 15. MOTHER'S MAIDEN NAME<br>Chan   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No  |                     | 16b. SOCIAL SECURITY NO.<br>216-78-0868T   |  |
| 17. INFORMANT<br>Mr. Pat Hay Fan   |                     | 3708 Brown Brook Ct. ADDRESS<br>Randallstown, Md. 21133  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u><br>4960<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Aspiration pneumonia w/ or Pulmonary embolism 7th.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Severe C.O.P.D.</u><br>4 years                   |                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 1/2 hrs.   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a), (b), and (c).<br><u>Diabetes Mellitus, Malnutrition, Anemia</u>   |                     |  |  |
| 19a. DATE OF OPERATION   |                     | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                           |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                     | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |                     |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                     | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |
| 21f. LOCATION<br>CITY OR TOWN COUNTY STATE   |                     |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3-19</u> , 19 <u>82</u> , to <u>4-10</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>4-10</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |                     |  |  |
| 22b. SIGNATURE<br>Edith C. Galvez  |                     | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |
| 22c. DATE SIGNED<br>4-10-82  |                     |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Edith C. Galvez M.D.  |                     | 22e. ADDRESS<br>5400 Old Court Rd 21133  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |                     | 23b. DATE<br>4/14/82   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br>Druid Ridge Cemetery   |                     | 23d. LOCATION<br>Pikesville, Md.   |  |
| 24. FUNERAL DIRECTOR NAME<br>Loring Byers Funeral Directors  |                     | 25a. DATE RECEIVED BY REGISTRAR<br>APR 13 1982   |  |
| 25b. REGISTRAR'S SIGNATURE<br>James J. Nathan  |                     |  |  |

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APR 13 1955  
JAMES H. HARRIS



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.Items, 14, & 15, G-567 5/28/82  
by F.H.D., / Gbj.STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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|  |                         |  |  |   |  |
|--|-------------------------|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>WILLIAM H. FARLEY</b>  |                         | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4 13 82</b>  |  | 2b. HOUR<br>MIN.<br><b>6:25 PM</b>  |  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 13 17</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>64</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>West Virginia</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b>  |                         | 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Greater Baltimore Med Center</b>            |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>School Teacher</b>  |                         | 12b. KIND OF BUSINESS OR INDUSTRY  |  | 13a. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 13b. COUNTY<br><b>Baltimore</b>  |                         | 13c. CITY OR TOWN<br><b>Balto</b>  |  | 13d. STREET ADDRESS<br><b>801 Shaw Court 21204</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Harry Robert Harry Farley</b>   |                         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Vereena Varina Hall Humphrey</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |                         | 16b. SOCIAL SECURITY NO.<br><b>224-24-4273A</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Doris C. Farley, Same As #13e</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <b>Multiple pulmonary infarcts</b><br><b>4292</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Severe arteriosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |                         |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |                         |  |  |   |  |
| 19a. DATE OF OPERATION   |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                         | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |  |   |  |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |                         | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                         | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4/1</b> , 19 <b>82</b> , to <b>4/13</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |                         | 22b. SIGNATURE<br><b>Rudiger Breiteneker</b>   |  |   |  |
| 22c. DATE SIGNED<br><b>4/14/82</b>   |                         | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Rudiger Breiteneker, M.D.</b>  |  |   |  |
| 22e. ADDRESS<br><b>GBMC, 6701 N. Charles St, Balto. Md. 21204</b>  |                         | 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |   |  |
| 23b. DATE<br><b>4-17-82</b>  |                         | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley Memorial</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Cockeysville, Balto. Md.</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Ruck Towson Funeral Home, Inc.</b>  |                         | ADDRESS<br><b>1050 York Rd. Towson, Md. 21204</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 16 1982</b>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |                         |  |  |   |  |

1991-1992

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified above.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 6 0 4

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Bertha Banyat Feiler</b>  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4-9-82</b>  |  | 2b. HOUR<br><b>1:35 A M</b>  |  |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 1 1900</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b> YRS.                                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New York</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>US</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto County</b> MD.                      |  |
| 10. CITY OR TOWN OF DEATH<br><b>CATONSVILLE</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Bridgeway Manor NC</b> | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Book Keeper</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>CLOTHING</b>                                 |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>md</b> 13b. COUNTY <b>Frederick</b> 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>1421 Laney Village #517</b>                                |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Max Feiler</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Sarah STENBUCK</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>113-10-0661</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>ELEANOR LAPIDES 119 WORDON AVE</b>                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>C.V.A.</b><br><b>2500</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) <b>ADRIACULAR FIBRILLATION.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>DIABETES MELLITUS</b> |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 mo -</b><br><b>3 mo -</b><br><b>5 yrs</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4-15</b> 19 <b>82</b> , to <b>4-8</b> 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>4-8</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.             |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Norman R. Korman MD</b>   |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>4-9-82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>NORMAN R. KORMAN</b>   |  | 22e. ADDRESS<br><b>3803 EDMONDSON AVE</b>   |  |  |  |
| 23a. BURIAL (CREMATION) REMOVAL<br>(SPECIFY)<br><b>CREMATION</b>   |  | 23b. DATE<br><b>4/12/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Toussaint Park</b>                          |  |
| 23d. LOCATION<br>CITY OR TOWN<br><b>Balto</b>  |  | COUNTY<br><b>md</b>   |  | STATE  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Sol Leiman &amp; Bros</b>   |  | ADDRESS<br><b>6010 Reisterstown Rd</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 15 1982</b>                                  |  |
|  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Thomas J. Nathan</b>                                |  |

*[Faint, illegible text, likely bleed-through from the reverse side of the page]*

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 2 0 8 6 0 5  
CERTIFICATE OF DEATH

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|  |   |   |   |  |  |
|--|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>IDA E. FELDMAN  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>APRIL 1, 1982                          |  | 2b. HOUR<br>1:30 P.M.  |
| 3. SEX<br>FEMALE   | 4. RACE<br>WHITE  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>JULY 4, 1895  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>86 YRS                                      | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.                   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH CITY OR TOWN, GIVE STREET ADDRESS)<br>7005 BOXFORD RD. (21215) |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE | 12b. KIND OF BUSINESS OR INDUSTRY<br>AT HOME                                   |  |
| 13a. STATE<br>MARYLAND   |   |   | 13b. COUNTY<br>BALTO.   | 13c. CITY OR TOWN<br>BALTIMORE   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>YERACHMIEL FRIEDLANDER   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>RACHAEL HURWITZ              |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES<br>NO   |   | 16b. SOCIAL SECURITY NO.<br>213-03-4921   | 17. INFORMANT<br>MRS. HINDA ESTERSON<br>7005 BOXFORD RD. BALTO., MD 21215     |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Adenocarcinoma Stomach</u><br>1519<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |   |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Arteriosclerotic Cardiovascular Disease</u>  |   |   |   |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>3/26</u> 19 <u>82</u> , to <u>4/1</u> 19 <u>82</u> , that (1) (we) lost saw the deceased <u>alive</u> on <u>above</u> (we) (did) (did not) view the body after death.  |   |   |   |  |  |
| 22b. SIGNATURE<br><u>H. Ronald Friedman</u>  |   | DEGREE<br><u>MD</u>   |   | 22c. DATE SIGNED<br>4-1-82   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>H. RONALD FRIEDMAN  |   | 22e. ADDRESS<br>6715 PARK HEIGHTS AVE. ((21215))  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |   | 23b. DATE<br>APR. 2, 1982   | 23c. NAME OF CEMETERY OR CREMATORY<br>BETH HAMEDROSH HAGODOL                  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>ROSEDALE BALTO. MD   |
| 24. FUNERAL DIRECTOR<br>NAME SOL LEVINSON & BROS., INC.<br>ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>APR 8 1982                                   |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. *[Faint, illegible handwritten text]*

2. *[Faint, illegible handwritten text]*

3. *[Faint, illegible handwritten text]*

STATE OF MARYLAND

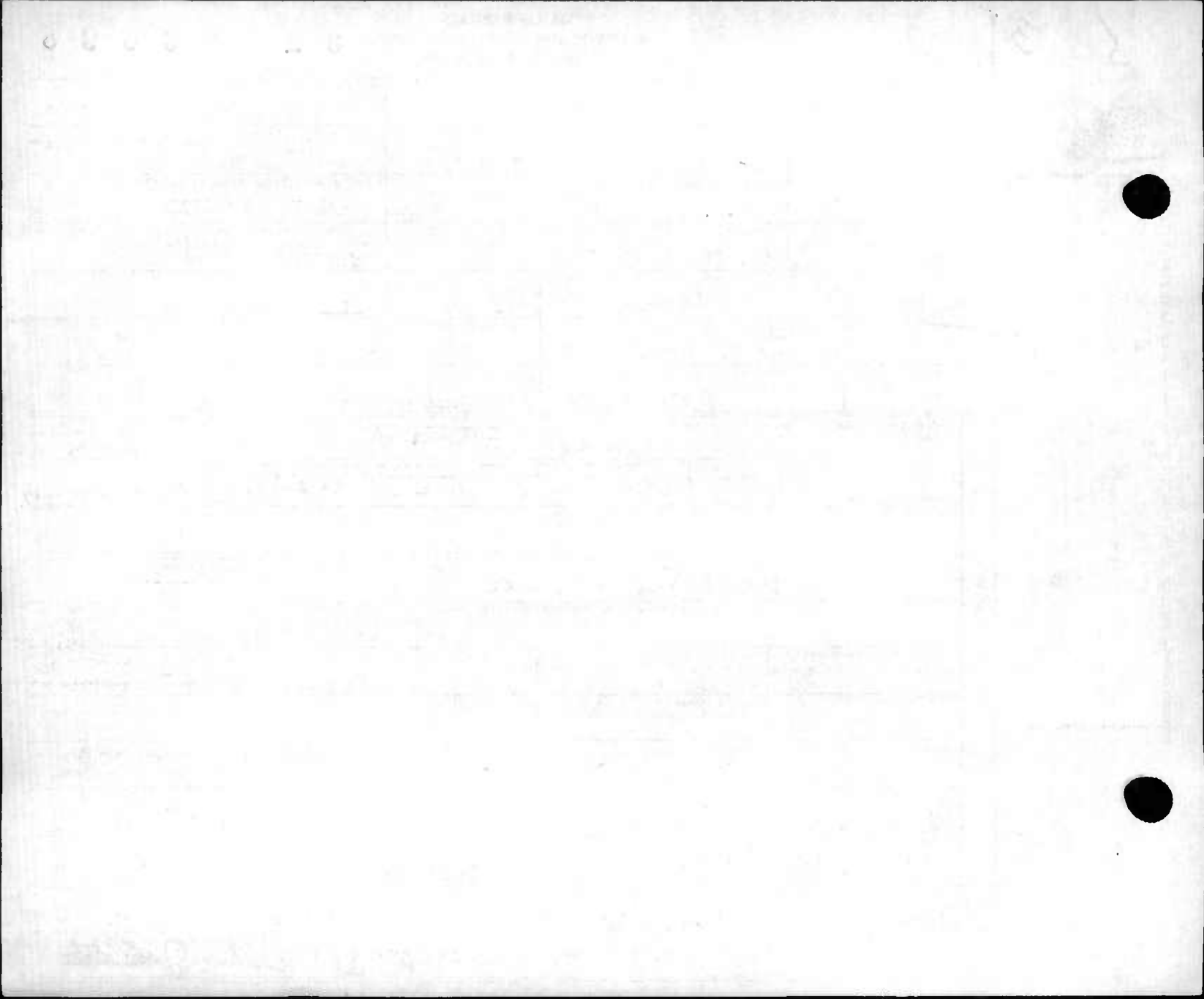
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 6 0 6

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |   |   |  |   |   |
|---|---|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>EARL Leroy FIFER</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4-8-82</b>   |   | 2b. HOUR<br><b>4:40a</b> M                                      |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>July 7, 1922</b>   |  | 6. AGE (IN YEARS (LAST BIRTHDAY))<br><b>59</b> YRS                        | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. <b>BALTIMORE CITY OR COUNTY OF DEATH</b><br><b>BALTIMORE COUNTY</b> MD |   |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST. JOSEPH HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Disabled</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY                               |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>   | 13c. CITY OR TOWN<br><b>Baltimore</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   | 13e. STREET ADDRESS<br><b>2102 Cloville Ave</b>  |   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>? Fifer</b>  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Unk</b>   |   |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   | 16b. SOCIAL SECURITY NO.<br><b>217-14-2104</b>  | 17. INFORMANT<br>ADDRESS<br><b>Miss Anna Wanger Same</b>  |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY.<br><b>4292</b><br>IMMEDIATE CAUSE (a) <b>Acute</b><br><b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>cardiovascular disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>days</b>     |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1<br><b>Diabetes mellitus</b> <b>DIABETES MELLITUS</b>   |   |   |  |   |   |
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |   |
| 22a. I certify that (X) this hospital attended the deceased from <b>4-2</b> , 19 <b>82</b> , to <b>4-8</b> , 19 <b>82</b> , that (X) we last saw the deceased alive on <b>4-8</b> , 19 <b>82</b> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) we (did) (not) view the body after death.  |   |   |  |   |   |
| 22b. SIGNATURE<br><b>Gracie V. Patricia</b>   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>4/8/82</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Gracie V. Patricia</b>  |   | 22e. ADDRESS<br><b>7620 YORK ROAD TOWSON MD 21204</b>   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   | 23b. DATE<br><b>Apr. 10, 1982</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood</b>   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>   |   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J Ruck Inc.</b>  |   | BALTIMORE, MARYLAND   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 12 1982</b>                       | 25b. REGISTRAR<br><b>Thomas J. [Signature]</b>                  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 6 0 7

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Mary Rose Filbey</b>   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4 23 82</b>   |  | 2b. HOUR<br><b>410 PM</b>  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 4 1891</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>90</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore county MD.</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Towson Convalescent Home</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Clerical</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Bank</b>   |  |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Karl Zorn</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Cunigunda Hertel</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>no</b>   |  |  |  |
| 16b. SOCIAL SECURITY NO.<br><b>215-32-7907</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Chesapeake City, Md.</b>  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>1. Myocardial + Resp Failure</b><br><b>4860</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 days</b>  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>ASCVD</b>   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/1</b> , 19 <b>77</b> , to <b>4/23</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>4/22</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.                        |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>R. MAFFERTON</b>  |  | DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br><b>4/23/82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>R. MAFFERTON</b>   |  | 22e. ADDRESS<br><b>660 KENILWORTH Dr - Balt, Md 21201</b>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>4/26/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moreland Mem. pk.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. MD</b>   |  |
| 24. FUNERAL DIRECTOR<br><b>Schumnek Funeral Home, Inc.</b>   |  | 25. DATE REC'D. BY REGISTRAR<br><b>APR 27 1982</b>   |  | 26. REGISTRAR'S SIGNATURE<br><b>James J. [Signature]</b>  |  |  |  |
| 2331 Brehms Lane, Balto. Md. 21213   |  |  |  |   |  |  |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 6 0 8

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|   |   |   |   |   |  |
|---|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST <u>Alexander</u> MIDDLE <u>Murray</u> LAST <u>FISHER</u> |   |   | 2a. DATE OF DEATH<br>MONTH <u>4</u> DAY <u>8</u> YEAR <u>'82</u>                      |   | 2b. HOUR<br><u>6:35 PM</u>                                     |
| 3. SEX<br><u>M</u>  | 4. RACE<br><u>W</u>   | 5. DATE OF BIRTH<br>MONTH <u>9</u> DAY <u>9</u> YEAR <u>'01</u>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><u>81</u> YRS.                                     |   | # UNDER 1 YEAR<br>MONTHS <u></u> DAYS <u></u>                  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><u>Maryland</u>                                       | 7b. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>Baltimore County</u> MD.                   |   |  |
| 10. CITY OR TOWN OF DEATH<br><u>Lutherville</u>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>College Manor</u> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>physician</u>  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><u>M.D.</u>               |
| 13a. STATE<br><u>MD</u>   |   |   | 13b. CITY OR TOWN<br><u>Ruxton</u>  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST <u>Tanon</u> MIDDLE <u></u> LAST <u>Fisher</u>                             |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <u>Katherine</u> MIDDLE <u>Le</u> LAST <u>Moyne</u> |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><u>NO</u>                     |   |   | 16b. SOCIAL SECURITY NO<br><u>220-30-2983</u>   |   | 17. INFORMANT<br><u>Wife</u> ADDRESS<br><u>1907 Ruxton Rd.</u> |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) Pneumonia

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH  
24 hoursPART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  
Huntington's Chorea

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (the undersigned) attended the deceased from <u>January 75</u> to <u>April 8</u> , 19 <u>82</u> , that (I) <input checked="" type="checkbox"/> lost<br>saw the deceased alive on <u>April 8</u> , 19 <u>82</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated<br>above, (I) <u>did</u> (did not) view the body after death. |  |  |  |  |  |
| 22b. SIGNATURE<br><u>W.B. Danoff, Jr.</u> M.D.  |  |  |  | 22c. DATE SIGNED<br><u>4/8/82</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>W.B. Danoff, Jr.</u>  |  |  |  | 22e. ADDRESS<br><u>11 E. Chase Baltimore 21202</u>                                   |  |

|  |                             |   |   |
|--|-----------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><u>cremation</u> | 23b. DATE<br><u>4/10/82</u> | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Westview Crematory</u> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Catonville Balto. Maryland</u> |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>Ambrose Funeral Home</u>      |                             | 25a. DATE REC'D. BY REGISTRAR<br><u>APR 13 1982</u>             |   |
| ADDRESS<br><u>1328 Sulphur Spring Rd.</u>                        |                             | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>                |   |

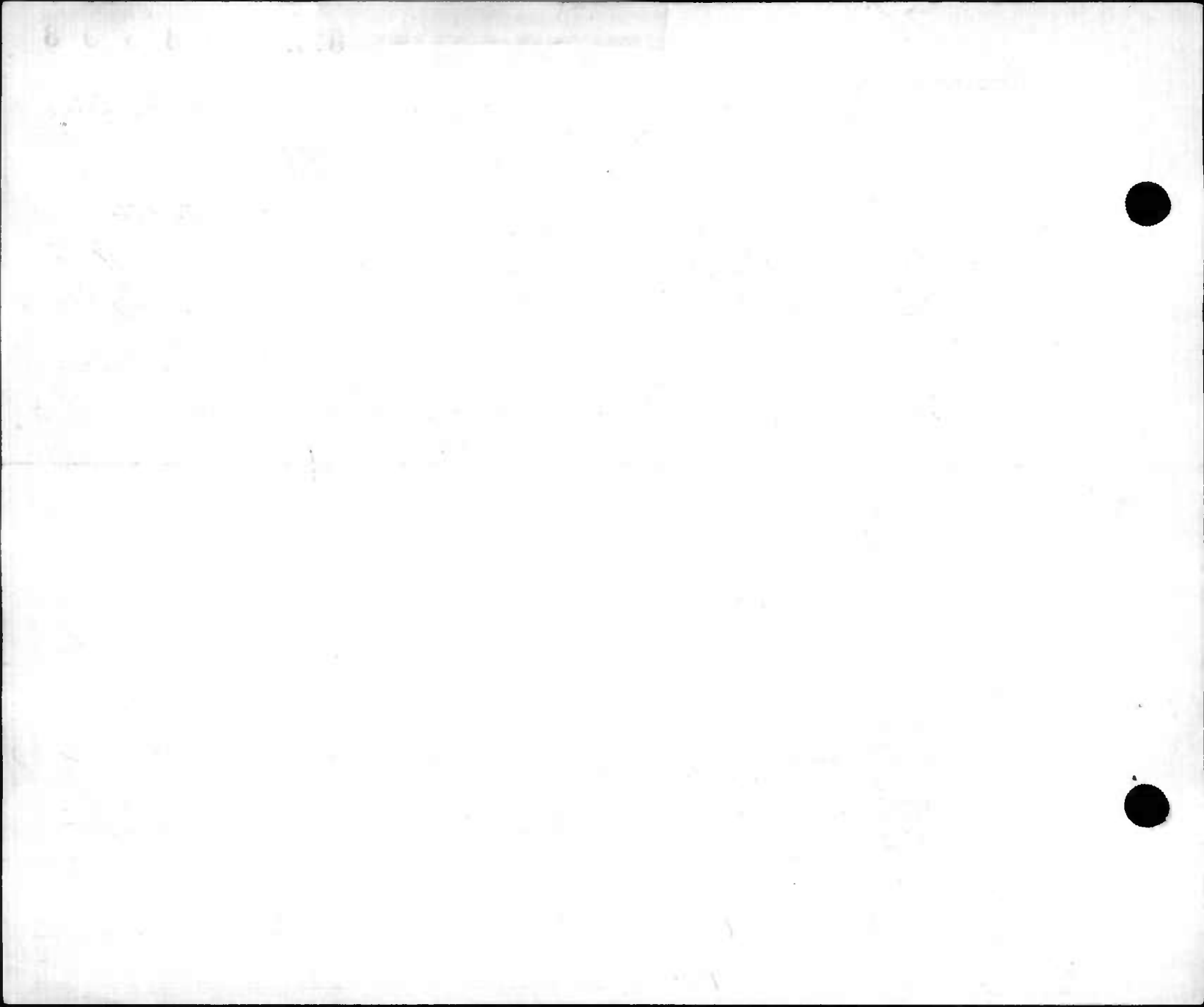
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 6 0 9

REG. NO.

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>THOMAS LAWRENCE FITZPATRICK</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>APRIL 10, 1982</b>                         |   | 2b. HOUR<br>M  |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>May 5, 1903</b>  |  | 6. AGE (IN YEARS (LAST BIRTHDAY))<br><b>78</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                             |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Josephs Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Appraiser</b> | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Real Estate</b>   |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   | 13c. CITY OR TOWN<br><b>Towson</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br><b>1065 Donnington Circle</b>   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Thomas Fitzpatrick</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Theresa Owens</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   | (IF YES, GIVE WAR OR DATES)  | 16b. SOCIAL SECURITY NO.<br><b>243-09-0822</b>  | 17. INFORMANT<br>ADDRESS<br><b>Eleanor R. Fitzpatrick Same</b>                       |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial infarct</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Coronary artery disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>menstr</b><br><b>4 hrs</b>  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |
| 22b. SIGNATURE<br><i>[Signature]</i>  |  |   |  | 22c. DATE SIGNED<br><b>4/12/82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>James C. Ricely, M.D.</b>   |  |   |  | 22e. ADDRESS<br><b>6701 N. Charles St. Towson, Md. 21204</b>                                    |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   | 23b. DATE<br><b>April 13, 1982</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore City Maryland</b>                    |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Mitchell-Wiedefeld Home, Inc.</b>  |  | ADDRESS<br><b>6500 York Rd. Balto., Md. 21212</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 14 1982</b>   |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 6 1 0

REG. NO.

|   |   |   |  |  |   |  |  |                  |          |  |
|---|---|---|--|--|---|--|--|------------------|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |   | FIRST   | MIDDLE   | LAST   | 2a. DATE OF DEATH   | MONTH                                      | DAY  | YEAR             | 2b. HOUR | a  |
| Earl J. FLECKENSTEIN JR.  |   |   |  |  | April 29, 1982  |  |  |                  | 2:30     | a  |
| 3 SEX   | 4 RACE  | 5 DATE OF BIRTH   |  | 6 AGE (IN YEARS LAST BIRTHDAY)   | IF UNDER 1 YEAR   |  | IF UNDER 24 HRS.   |                  |          |  |
| MALE  | CAUCASIAN   | 07 25 38  |  | 43   | MONTHS DAYS   |  | HOURS MIN.   |                  |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH  |   |  |  |                  |          |  |
| MARYLAND  | USA   |   |  | Baltimore County MD.   |   |  |  |                  |          |  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |                  |          |  |
| ROSEDALE  | FRANKLIN SQUARE HOSPITAL  |   | PHOTO ENGRAVER   |  | ALCO GRAUVRE  |  |  |                  |          |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |   |   |  |  |   |  |  |                  |          |  |
| 13a. STATE  | 13b. COUNTY   | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?   | 13e. STREET ADDRESS   |  |  |                  |          |  |
| MARYLAND  | BALTIMORE   | ROSEDALE  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 1814 ELLINWOOD RD.  |  |  |                  |          |  |
| 14. FATHER'S NAME   |   | 15. MOTHER'S MAIDEN NAME  |  |  |   |  |  |                  |          |  |
| EARL J. FLECKENSTEIN SR.  |   | MABEL   |  |  |   |  |  |                  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |   | 16b. SOCIAL SECURITY NO.  |  | 17 INFORMANT ADDRESS   |   |  |  |                  |          |  |
| NO  |   | 217345317   |  | VICTOR FLECKENSTEIN 4 ESTERO PLACE   |   |  |  |                  |          |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardio-pulmonary Arrest</u><br><u>1991</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Metastatic Carcinoma</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF |   |   |  |  |   |  |  |                  |          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a  |   |   |  |  |   |  |  |                  |          |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                  |          |  |
|   |   |   |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                  |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |  |                  |          |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |                  |          |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>April 22</u> , 19 <u>82</u> , to <u>April 29</u> , 19 <u>82</u> , that (we) last saw the deceased alive on <u>April 29</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.                            |   |   |  |  |   |  |  |                  |          |  |
| 22b. SIGNATURE  |   | DEGREE  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |  |  | 22c. DATE SIGNED |          |  |
| <u>Robert L. Lyles</u>  |   |   |  |  |   |  |  | 4-29-82          |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |   | 22e. ADDRESS  |  |  |   |  |  |                  |          |  |
| Robert Lyles M.D.   |   | 9000 Franklin Square Drive 21237  |  |  |   |  |  |                  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |   | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |  |                  |          |  |
| BURIAL  |   | 5/1/82  |  | BALTIMORE CEMETERY   |   | BALTO. --- md.                             |  |                  |          |  |
| 24. FUNERAL DIRECTOR<br>NAME  |   | ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE   |   |  |  |                  |          |  |
| <u>John G. Gwalt</u>  |   | 1211 Chesaco Ave.   |  | APR 30 1982 <u>James J. Van Winkle</u>   |   |  |  |                  |          |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.DHMH - 16 50M 1/81  
(VRA 15, 4)STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 6 1 1

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |   |   |   |  |
|--|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Elizabeth W. Flook</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 14, 1982</b>                                    |   | 2b. HOUR<br>M<br><b></b>                     |
| 3. SEX<br><b>F</b>   | 4. RACE<br><b>W</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Jan. 5, 1910</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>72</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b></b>    |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>VA.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore Co., MD.</b>                         |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>135 Versailles Circle Apt. A-1</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>            |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b></b> |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.</b>   |  |   | 13b. COUNTY<br><b>Baltimore</b>   |   |  |
| 13c. CITY OR TOWN<br><b>Towson</b>   |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |
| 13e. STREET ADDRESS<br><b>135 Versailles Circle Apt. A-1</b>   |  |   |   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Ward</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Edna Morris</b>                             |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>212 01 7359</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Margaret Ingham Franklin Lakes, N. J.</b>             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Pulmonary Emphysema</b><br><b>4920</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Arteriosclerotic Heart Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>6 YRS</b><br><b>5 YRS</b> |  |   |   |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b></b>  |  |   |   |   |  |
| 19a. DATE OF OPERATION<br><b></b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b></b>   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>      |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b></b> |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b></b>   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b></b>                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>AUG 57</b> , 19 <b>1971</b> , to <b>DEC 18</b> , 19 <b>80</b> , that (I) (we) lost<br>saw the deceased alive on <b>DEC 18</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) did not view the body after death.   |  |   |   |   |  |
| 22b. SIGNATURE<br><b>John M. Scott</b>   |  | DEGREE<br><b>M.D.</b>   |   | 22c. DATE SIGNED<br><b>4/15/82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JOHN M. SCOTT</b>  |  | 22e. ADDRESS<br><b>601 W. NORTHEEN PENNA 21240</b>  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>4/17/82</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Marks Cem.</b>                               |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Petersville, Md.</b>  |  |   |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>MITCHELL-WIEDEFELD HOME, INC. 6500 York Rd.</b>   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 19 1982</b>   |   |  |
|  |  |   | 25b. REGISTRAR'S SIGNATURE<br><b></b>   |   |  |

MEDICAL CERTIFICATION

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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FOR  
1 - STATE  
REGISTRAR

REG. NO.

|   |   |   |   |  |  |
|---|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>BEVERLY A FLORANCIC  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>APRIL 25, 1982       |  | 2b. HOUR<br>6:30A M  |
| 3. SEX<br>female  | 4. RACE<br>white  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Sept. 16, 1932  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>49 YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Indiana   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.                             |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Josephs Hospital |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Unemployed- Disabled |  |
| 13a. STATE<br>MD  |   |   | 13b. COUNTY<br>Balto.                                       | 13c. CITY OR TOWN<br>Baltimore   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Walter McCarty  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Ada Robins |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>313-30-6733  |   | 17. INFORMANT<br>ADDRESS<br>3514 Rolling Rd.<br>Miss Elaine McCarty Baltimore, Md. 21207 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Hepatic Failure</u><br>5715<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Cirrhosis of the Liver</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Intestinal bypass, 1971</u>   |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |   |   |   |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)            |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 19 19 82, to April 25 19 82, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on April 25 19 82, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death. |   |   |   |  |  |
| 22b. SIGNATURE<br>Henry S. Crist, MD  |   |   |   | 22c. DATE SIGNED<br>4/25/82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Henry S. Crist MD  |   |   |   | 22e. ADDRESS<br>7620 YORK RD.  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |   | 23b. DATE<br>4/29/82  | 23c. NAME OF CEMETERY OR CREMATORY<br>Bel Air Mem. Gardens  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Bel Air Harford MD   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Loring Byers Funeral Directors<br>8728 Liberty Rd. Randallstown, Md. 21133  |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br>APR 27 1982   |  |
|   |   |   |   | 25b. REGISTRAR'S SIGNATURE<br>James Van Natta  |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use of the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

SECRET

APRIL 20 1954

BALTIMORE

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 10-10-83 BY SP-5 JRS/STP

U.S. DEPT. OF JUSTICE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 6 1 3

REG. NO.

|  |   |   |  |   |  |
|--|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Katherine W FORD</i>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>April 27 1982</i>                        |   | 2b. HOUR<br><i>3 P M</i>   |
| 3. SEX<br><i>Female</i>  | 4. RACE<br><i>White</i>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>July 17 1905</i>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>79</i> YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Coil Co</i>  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore County</i> MD.                |   |  |
| 10. CITY OR TOWN OF DEATH<br><i>Towson</i>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Manor Care Nursing Home</i> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Chemist</i> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Chemical</i>   |
| 13a. STATE<br><i>Md</i>  |   | 13b. COUNTY<br><i>Balto</i>   | 13c. CITY OR TOWN<br><i>Towson</i>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><i>620 Highland Ave</i>   |
| 14. FATHER'S NAME<br>FIRST MIDDLE<br><i>H. Lynn Worthington</i>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE<br><i>Caroline Kirk</i>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <i>NO</i>                  |  |
| 16b. SOCIAL SECURITY NO.<br><i>215-07-7757</i>   |   | 17. INFORMANT<br>ADDRESS <i>Gregory Kline, 1252 Charlotte St, Mt Airy, Md 21093</i>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cerebral Aneurysm</i><br>4360<br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cerebral Arteriosclerosis</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (c) |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>4 days</i>  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |   |   |  |   |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) <i>(this hospital)</i> attended the deceased from <i>November 81</i> , to <i>27 April 82</i> , that (I) <i>(myself)</i> saw the deceased alive on <i>27 April 1982</i> , and that in (my) <i>own</i> opinion death occurred on the date and hour and from the causes stated above, (I) <i>(we)</i> (did) (did not) view the body after death.            |   |   |  |   |  |
| 22b. SIGNATURE<br><i>Walter T. Kees</i>  |   | DEGREE<br><i>MD</i>   |  | 22c. DATE SIGNED<br><i>27 April 82</i>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>WALTER T. KEES</i>   |   | 22e. ADDRESS<br><i>Monkton Hill</i>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Removal</i>  |   | 23b. DATE<br><i>4/27/82</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |   | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><i>Anatomy Board Balto., Md.</i>  |  |   |  |
| 25a. DATE REC'D. BY REGISTRAR  |   | 25b. REGISTRAR<br><i>[Signature]</i>  |  |   |  |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical examination must be held.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 6 1 4

REG. NO.

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Sr. MARY H FORTUN</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4 23 82</b>            |   | 2b. HOUR<br>M<br><b>AM</b>   |
| 3. SEX<br><b>FEMALE</b>   | 4. RACE<br><b>WHITE</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 23 08</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. <b>BALTIMORE CITY OR COUNTY OF DEATH</b><br><b>BALTIMORE COUNTY</b> MD.                      |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST JOSEPH'S HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |   | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY<br><b>BALTO</b>   | 13c. CITY OR TOWN<br><b>GLEN ARM</b>                             | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br><b>11630 GLEN ARM RD</b>  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Josephine Berkopec</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>215-76-1649</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Sister Louis Marie Koesters 11630 Glen Arm Rd.</b>               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrest</b><br><b>4292</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>ASCUD</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)                             |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 years</b>   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>July 1979</b> to <b>April 23</b> , 19 <b>82</b> , that (we) (we) last saw the deceased alive on <b>April 22</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |
| 22b. SIGNATURE<br><b>L. Boas MD</b>   |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>April 23 82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>L. BOAS MD</b>  |  | 22e. ADDRESS<br><b>50 SCOTT AVE Rd Cockeysville Md</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>Burial</b>  | 23b. DATE<br><b>4-26-82</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Sisters Cemetery</b>   |  | 23d. LOCATION<br>COUNTY STATE<br><b>Glen Arm, Baltimore, Md.</b>                                |  |
| 24. FUNERAL DIRECTOR<br><b>Curran Funeral Home</b>  |  | 25. DATE REC'D. BY REGISTRAR<br><b>MAY 7 1982</b>   |  | 26. REGISTRAR'S SIGNATURE<br><b>James J. Nathan</b>   |  |

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FORN  
UNITED STATES  
BALTIMORE COUNTY

ST. JOSEPH'S HOSPITAL

BALTO GLEN AVE

212 11-1049



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 6 1 5

REG. NO.

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>WILLIAM E. FOSTER</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4 16 '82</b>                           |  | 2b. HOUR<br>MIN.<br><b>1:35A</b>   |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>CAUCASIAN</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 27 '18</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>63</b>   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>W. VA.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.                              |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>GBMC-6701 N. CHARLES ST.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>STEEL</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY<br><b>BALTO</b>   | 13c. CITY OR TOWN<br><b>ESSEX</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 13e. STREET ADDRESS<br><b>412 GERRIES AVE</b>  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JOHN FOSTER</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>PEARL MEADOWS</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>UNK</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>234-22-1338</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>WILMA FOSTER ABOVE</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY ARREST</b><br><b>4960</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>RIGHT SIDED PNEUMOTHORAX</b><br>(c) <b>CHRONIC OBSTRUCTIVE LUNG DISEASE</b> |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>3-20 82</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>4-16 82</b> |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>4-16 82</b>  |  | 21f. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>4-16 82</b>                                     |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4-16 82</b> to <b>4-16 82</b> , that (I) (we) last saw the deceased alive on <b>4-16 82</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Gerard A. Garguilo</b>   |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>4-16-82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>GERARD A. GARGUILO, M.D.</b>  |  | 22e. ADDRESS<br><b>GBMC-6701 N. CHARLES ST.</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>4/19/82</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>HIGH VIEW CEM.</b>                      |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>HARFORD MD</b>  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>J.E. CONNELL</b>   |  | ADDRESS<br><b>300 MACE</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 21 1982</b>  |  |
|   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>James J. Nathan</b>   |  |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be contacted at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |   |  | REG. NO. 8 2 0 8 6 1 6  |  |                      |  |
|--|--|---|--|---|--|--|--|---|--|---|--|----------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>ABRAHAM FRAYMAN   |  |   |  |   |  |  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>4-13-82   |  | 2b. HOUR<br>9:02 P M |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>5 10 02  |  | 6. AGE (IN YEARS (LAST BIRTHDAY) YRS.<br>79  |  | 7. IF UNDER 1 YEAR MONTHS DAYS  |  | 8. IF UNDER 24 HRS. HOURS MIN.  |  |                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>POLAND  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALT. COUNTY MD                                      |  |   |  |   |  |                      |  |
| 10. CITY OR TOWN OF DEATH<br>RANDALSTOWN   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>BALT. COUNTY GEN. HOSP. |  |   |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>TAILOR           |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>CLOTHING   |  |                      |  |
| 13a. STATE<br>MD   |  | 13b. COUNTY<br>MONTGOMERY   |  | 13c. CITY OR TOWN<br>SILVER SPRING  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>706 LAMBERTON DR. (20902)                                  |  |   |  |                      |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>MOISHE FRAYMAN  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>UNKNOWN   |  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO           |  |   |  |                      |  |
| 16b. SOCIAL SECURITY NO.<br>103-26-0350  |  |   |  | 17. INFORMANT ADDRESS<br>1283 CONEY ISLAND AVE<br>WEST END FUNERAL CHAPEL BKLYN, N.Y. (11230)   |  |  |  |   |  |   |  |                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4360 stroke<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: weeks |  |   |  |   |  |  |  |   |  |   |  |                      |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |  |  |   |  |   |  |                      |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)               |  |   |  |   |  |                      |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  |  | 21f. LOCATION CITY OR TOWN COUNTY STATE   |  |   |  |                      |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-5-19-82 to 4-13-19-82, that (I) (we) last saw the deceased alive on 4-13-19-82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |   |  |   |  |                      |  |
| 22b. SIGNATURE<br>Soonchul Hong  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |  |  | 22c. DATE SIGNED<br>4-13-82   |  |   |  |                      |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>SOONCHUL HONG   |  |   |  | 22e. ADDRESS<br>Baltimore County General Hospital   |  |  |  |   |  |   |  |                      |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  |   |  | 23b. DATE<br>4-16-82  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>WELLWOOD CEM   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>FARMINGDALE, N.Y.                      |  |   |  |                      |  |
| 24. FUNERAL DIRECTOR NAME<br>SOL LEVINSON & BROS.<br>6010 REISTERSTOWN RD. BALTIMORE, MD. 21215  |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>APR 21 1982   |  | 25b. REGISTRAR'S SIGNATURE<br>Frances Jean Nathan                                 |  |   |  |                      |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |   |  |   |  |  |  | 8 2 0 8 6 1 7 |  |
|---|--|--|--|---|--|---|--|--|--|---------------|--|
| 1. FOR STATE REGISTRAR  |  |  |  |   |  |   |  |  |  | REG. NO.      |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>ESTHER G. FREYER</b>  |  |  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>4 1 1982</b>   |  | 2b. HOUR<br><b>4:20P M</b>                                   |  |               |  |
| 3. SEX<br><b>F</b>  |  | 4. RACE<br><b>CAUCASIAN</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>8 21 1923</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS<br><b>58</b>  |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS HOURS MIN.    |  |               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N, Carolina</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County MD.</b>   |  |  |  |               |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>4 Ayr Court 21236</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>house-wife</b>                                      |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>home</b>             |  |               |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. CITY OR TOWN<br><b>Baltimore</b>  |  | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13d. STREET ADDRESS<br><b>1235 Broening Highway</b>   |  |  |  |               |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Dorsett Cress</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Bertha Hooks</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>   |  |   |  |  |  |               |  |
| 16b. SOCIAL SECURITY NO.<br><b>246 18 7006</b>  |  | 17. INFORMANT ADDRESS<br><b>Herbert Freyer 4 Ayr Court 21236</b>   |  |   |  |   |  |  |  |               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Intestinal obstruction</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Metastatic adenocarcinoma</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Adenocarcinoma of rectum</b><br>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST<br><b>3 wks 8 mo 2 yrs</b> |  |  |  |   |  |   |  |  |  |               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>no</b>  |  |  |  |   |  |   |  |  |  |               |  |
| 19a. DATE OF OPERATION<br><b>7/31/81</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Intest. obstruct. metastatic</b>  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |               |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |               |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>March 19 75</b> to <b>April 19 82</b> , that (I) (we) lost saw the deceased alive on <b>FEB 4 19 82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |  |  |               |  |
| 22b. SIGNATURE<br><b>Paul G. Herold</b>   |  | DEGREE<br><b>MD</b>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br><b>4/2/82</b>   |  |  |  |               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>PAUL G. HEROLD M.D.</b>   |  | 22e. ADDRESS<br><b>10 W. MADISON ST 21201</b>  |  |   |  |   |  |  |  |               |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>4/5/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore Md</b>  |  |  |  |               |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Walter Dabrowski</b>  |  |  |  | ADDRESS<br><b>1005 Dundalk Avenue</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 5 1982</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>James J. K. [Signature]</b> |  |               |  |

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ESTHER C. FREYER

211725 25

Baltimore County USA

Baltimore + Apr Court 21230 house-wife home

Maryland Baltimore x 1235 Broening Highway

Dorsett Gross Bertha books

no 240 18 7006 Herbert Freyer + Apr Court 21230

*Handwritten notes:*  
Herbert Freyer  
Baltimore  
1235 Broening Highway  
Baltimore  
books

211725 x

*Handwritten notes:*  
FEB 1 1961  
MAY 1 1961  
JUN 1 1961  
JUL 1 1961  
AUG 1 1961  
SEP 1 1961  
OCT 1 1961  
NOV 1 1961  
DEC 1 1961

Baltimore 4/2/81

1005 Sandale Avenue

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 6 1 8

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |  |  |   |  |  |
|--|--|--|--|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Marie B FREYER</b>                       |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 28, 1982</b>   |  |  | 2b. HOUR<br><b>6:10am</b>   |  |  |
| 3 SEX<br><b>FEMALE</b>   |  |  | 4 RACE<br><b>WHITE</b>   |  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>MARCH 3, 1926</b>  |  |  |
| 6 BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>WEST VA.</b>                      |  |  | 7a. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>ESSEX</b>   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>FRANKLIN SQUARE HOSPITAL</b> |  |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County MD.</b>  |  |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>AT HOME</b> |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |   |  |  |

|   |  |  |  |  |  |   |  |  |
|---|--|--|--|--|--|---|--|--|
| 13a. STATE<br><b>MD.</b>  |  |  | 13b. COUNTY<br><b>BALTO.</b>   |  |  | 13c. CITY OR TOWN                                 |  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>DEWY BARBER</b>                       |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ORPHA BEASLY</b>         |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b> |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>23640 5171</b> |  |  | 17. INFORMANT<br>ADDRESS<br><b>FAMILY RECORDS</b> |  |  |

|  |  |  |
|--|--|--|
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Massive Acute Myocardial Infarction</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Arteriosclerotic Cardiovascular Disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(c) _____ |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|--|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: \_\_\_\_\_

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>April 23</b> , 19 <b>82</b> , to <b>April 28</b> , 19 <b>82</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>April 28</b> , 19 <b>82</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><i>Kathryn Yamamoto</i>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>4/28/82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Kathryn Yamamoto, M.D.</b>  |  |  |  | 22e. ADDRESS<br><b>9000 Franklin Square Dr. Balto., MD 21237</b>   |  |   |  |

|   |  |                                 |  |   |  |  |  |
|---|--|---------------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>                       |  | 23b. DATE<br><b>MAY 1, 1982</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GARDENS OF FAITH</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ESSEX BALTO. MARYLAND</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>EVANS FUNERAL CHAPEL 8800 HARFORD R.</b> |  |                                 |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 5 1982</b>            |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Van Nuthen</i>                    |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |   |  |   |  |   |  | REG. NO. 8 2 0 8 6 1 9 |  |
|--|--|--|---|---|--|---|--|---|--|------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>WILLIAM HENRY FULLER</b>   |  |  |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>April 21, 1982</b>                      |   |  | 2b. HOUR<br><b>1:11p M</b>  |  |                        |  |
| 3. SEX<br><b>M</b>   |  | 4. RACE<br><b>W</b>  |   | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>11/6/19</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>62</b> YRS                                  |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.  |  |                        |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MINN.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD                |  |   |  |                        |  |
| 10. CITY OR TOWN OF DEATH<br><b>ROSSVILLE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>FRANKLIN SQ.</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S.</b>  |  |                        |  |
| 13a. STATE<br><b>MD.</b>   |  |  | 13b. COUNTY<br><b>BALTO</b>   |   | 13c. CITY OR TOWN<br><b>MIDDLE RIVER</b>                                       |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 13e. STREET ADDRESS<br><b>9753 MATZON RD</b> |                        |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>FRANK FULLER</b>   |  |  |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>MARGARET COLLINS</b>          |   |  |   |  |                        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>508 14 7982</b>                      |   | 17. INFORMANT ADDRESS<br><b>NORMA FULLER ABOVE</b>                             |   |  |   |  |                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Pyelonephritis with Sepsis</b><br><b>5908</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |   |   |  |   |  |   |  |                        |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____   |  |  |   |   |  |   |  |   |  |                        |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                        |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |  |   |  |                        |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |   |  |   |  |                        |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>April 6</b> , 19 <b>82</b> , to <b>April 21</b> , 19 <b>82</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>April 21</b> , 19 <b>82</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. |  |  |   |   |  |   |  |   |  |                        |  |
| 22b. SIGNATURE<br><b>Dr. J. Richter</b>  |  |  |   |   | DEGREE   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>4-21-82</b>           |                        |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. J. Richter</b>   |  |  |   |   | 22e. ADDRESS<br><b>9000 Franklin Square Drive 21237</b>                        |   |  |   |  |                        |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  |  | 23b. DATE<br><b>4/24/82</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MORELANDS</b>                         |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>BALTO. MD.</b>   |   |  |                        |  |
| 24. FUNERAL DIRECTOR NAME<br><b>J. G. CONNELLY</b> ADDRESS<br><b>SONS</b>  |  |  |   |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 28 1982</b>                               |  |   |  |                        |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Thomas J. Richter</b>   |  |  |   |   |  |   |  |   |  |                        |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTER

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 6 2 0  
REG. NO.

|  |  |   |   |   |   |
|--|--|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>HARRY E. FUNK   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>APRIL 3, 1982                        |   | 2b. HOUR<br>M   |
| 3. SEX<br>MALE   | 4. RACE<br>WHITE   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>OCTOBER 1, 1909   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>72 YRS   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.                |   |   |
| 10. CITY OR TOWN OF DEATH<br>TOWSON  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ST. JOSEPH HOSPITAL |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>SMELTER | 12b. KIND OF BUSINESS OR INDUSTRY<br>STEEL  |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE MD. 13b. COUNTY |  |   | 13c. CITY OR TOWN<br>BALTIMORE  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>1035 REVERDY RD. 21212                   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>HARRY E. FUNK SR.  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>LEUDA RITTER   |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>213-09-9960   |   | 17. INFORMANT ADDRESS<br>MRS. MARGARET C. FUNK 1035 REVERDY RD.             |   |   |

|   |  |  |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pneumogenic Carcinoma</u><br>1629<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>5 months |
|---|--|--|

|   |  |  |  |
|---|--|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |  |  |  |
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-1-82 to 4-3-82, that (we) last saw the deceased alive above, (I) (we) (did) (did not) view the body after death, and that in my (our) opinion death occurred on the date and hour and from the causes stated |  |  |  |
| 22b. SIGNATURE<br><u>Robert E. Stoner</u>   | DEGREE   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED<br>4-5-82   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ROBERT E. STONER MD.   |  | 22e. ADDRESS<br>714 YORK RD.   |  |

|   |                           |   |   |
|---|---------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL                                 | 23b. DATE<br>APR. 7, 1982 | 23c. NAME OF CEMETERY OR CREMATORY<br>Dulaney Valley Mem. Gdns. | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>COCKEYSVILLE BALTO. MD. |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>MITCHELL-WIEDEFELD HOME 6500 YORK RD. 21212 |                           | 25a. DATE REC'D. BY REGISTRAR<br>APR 8 1982                     | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>                      |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH - 16 50M 1/81  
(VRA 15, 4)STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 6 2 1

REG. NO.

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Genevieve M Gahan</b>   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4 26 82</b>  |  | 2b. HOUR<br><b>4:30 PM</b>   |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>03 15 62</b>  |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b> YRS.  |  | 7a. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>   |  | 7b. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>BALTO.</b>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO COUNTY MD.</b>  |  | 10. CITY OR TOWN OF DEATH<br><b>BALTO COUNTY</b>   |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>VALLEY NRSNG + Convalescent CENTER</b>   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOSTESS</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>RESTAURANT</b>   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE <b>Md</b> 13c. CITY OR TOWN <b>BALTO.</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>5425 BELAIR RD.</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>SHIPLEY</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MARY GRAHAM</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>   |  |
| 16b. SOCIAL SECURITY NO.<br><b>214-03-4900</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>MR. JAMES P. GAHAN, JR. 18 E. QUERLER AVE.</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic Coronary Artery Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Cerebrovascular Accident</b>   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |  |  |  |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12-26-80</b> to <b>4-26-82</b> , that (I) (we) lost<br>saw the deceased alive on <b>4-20-82</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                                 |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Marion C. Rowacewski</b>  |  | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>4-26-82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MARION C. ROWACEWSKI</b>   |  | 22e. ADDRESS<br><b>8604 HARFORD RD.</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>4-29-1982</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTO. U.S. NATIONAL</b>  |  |
| 23d. LOCATION<br>CITY OR TOWN<br><b>BALTO. Md.</b>   |  | 23e. DATE REC'D. BY REGISTRAR<br><b>APR 27 1982</b>  |  | 23f. REGISTRAR'S NAME<br><b>James J. Nathan</b>  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 6 2 2

REG. NO.

|  |   |   |  |  |  |
|--|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Rita DeVittorio Galeone</b>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 16, 1982</b>                         |  | 2b. HOUR<br>M<br><b></b>   |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>May 11, 1900</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b> YRS.                              | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b></b>  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Italy</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.            |  |
| 10. CITY OR TOWN OF DEATH<br><b>Timonium</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>233 W. Timonium Rd.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Custodian</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>School System</b>  |
| 13a. STATE<br><b>Md.</b>   |   |   | 13b. COUNTY<br><b>Balto.</b>   | 13c. CITY OR TOWN<br><b>Timonium</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Frank DeVittorio</b>  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Maria Pavone</b>                 |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>---</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Frank P. Galeone, 233 W. Timonium Rd.</b>       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Arteriosclerotic Cardiovascular Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b> |   |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b></b>   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b></b>   |   |   |  |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b></b>                   |  |
| 22a. I certify that (1) this hospital attended the deceased from <b>April 15</b> 19 <b>82</b> , to <b>April 16</b> 19 <b>82</b> , that (1) (we) lost saw the deceased alive on above, (1) (we) that (did not) see the body after death.  |   |   |  |  |  |
| 22b. SIGNATURE<br><b>Charles E. Carr Jr</b> DEGREE <b>MD</b>   |   |   |  | 22c. DATE SIGNED<br><b>4/16/82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Charles E. Carr, M.D.</b>  |   |   |  | 22e. ADDRESS<br><b>3900 N. Charles Street, Suite 109</b>                       |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>Burial</b>   |   | 23b. DATE<br><b>4/19/82</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer Cem.</b>                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>        |  |
| 24. FUNERAL DIRECTOR<br><b>Lemmon-Mitchell-Wiedefeld, Inc.</b> ADDRESS <b>10 W. Padonia Rd.</b>  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 19 1982</b>                                  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles E. Carr</b>                           |  |

22085



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 2 0 8 6 2 3  
REG. NO.

|  |  |   |  |  |  |  |
|--|--|---|--|--|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>ARIE S. GAMBER   |  |   | 2a DATE OF DEATH MONTH DAY YEAR<br>April 2, 1982 |  | 2b HOUR<br>3:30A.M.                                    |  |
| 3 SEX<br>Male  |  | 4 RACE<br>White   |  | 5 DATE OF BIRTH MONTH DAY YEAR<br>October 28, 1907   |  |  |
| 6 AGE (IN YEARS LAST BIRTHDAY)<br>74 YRS   |  | 7b CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |
| 9a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Balto. Co. Md.   |  | 9b BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore Co. MD.   |  | 10 CITY OR TOWN OF DEATH<br>Reisterstown   |  |  |
| 11a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE Md. 13b COUNTY Balto. 13c CITY OR TOWN Reisterstown   |  | 11b NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>11212 Thompson Ave. |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired Balto. Co. Highway Dept  |  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>William Gamber   |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Ide Tillman  |  |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |  | 16b SOCIAL SECURITY NO.<br>219-36-1150  |  | 17 INFORMANT ADDRESS<br>Mrs. Isabell Q. Gamber Reisterstown, Md.   |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction<br>4100 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>immed. |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.<br>Diabetes Mellitus - Atherosclerosis  |  |   |  |  |  |  |
| 19a DATE OF OPERATION  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f LOCATION CITY OR TOWN COUNTY STATE   |  |  |
| 22a I certify that (I) (this hospital) attended the deceased from 7-6-81 to 4-2-82, 19_____, that (I) (we) last saw the deceased alive on 2-2-82, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.                    |  |   |  |  |  |  |
| 22b SIGNATURE<br>Darold K. Beard   |  | DEGREE  |  | 22c DATE SIGNED<br>4-2-82  |  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>Darold K. Beard, M. D.   |  | 22e ADDRESS<br>11 E. Chestnut Hill La., Reisterstown, Md.   |  |  |  |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b DATE<br>April 5, 82   |  | 23c NAME OF CEMETERY OR CREMATORY<br>Deer Park Cemetery  |  |  |
| 23d LOCATION CITY OR TOWN COUNTY STATE<br>Reisterstown, Md.  |  | 24 FUNERAL DIRECTOR NAME ADDRESS<br>Elaine Funeral Home Reisterstown, Md. 21136   |  |  |  |  |
| 25a DATE REC'D BY REGISTRAR<br>APR 5 1982  |  | 25b REGISTRAR'S SIGNATURE   |  |  |  |  |

6 5 0 8 0 2 8

April 2, 1902

April 16, 1902

April 16, 1902

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April 16, 1902

April 16, 1902

April 16, 1902

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 6 2 4

REG. NO.

|   |  |  |  |  |  |   |  |   |  |
|---|--|--|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST MIDDLE LAST  |  | 2a. DATE OF DEATH  |  | MONTH DAY YEAR  |  | 2b. HOUR                                |  |
| SOPHIE  |  | GARELICK   |  | TUESDAY, APRIL 6, 1982   |  | 5:35PM  |  |   |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR                         |  |
| FEMALE  |  | WHITE  |  | APRIL 2, 1899  |  | 83  |  | MONTHS DAYS HOURS MIN.                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  | MD.                                     |  |
| LITHUANIA   |  | USA  |  |  |  | BALTIMORE COUNTY  |  |   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |   |  |
| RANDALLSTOWN  |  | BALTIMORE COUNTY GENERAL HOSPITAL  |  | HOUSEWIFE  |  | HOME  |  |   |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS                     |  |
| MARYLAND  |  | BALTIMORE  |  | RANDALLSTOWN   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 4001 STARBROOK RD. (21133)              |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS                   |  |
| UNKNOWN   |  | UNKNOWN  |  | NO   |  | 213-12-95238  |  | ELI GARELICK 4001 STARBROOK RD. (21133) |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  | PART 1. DEATH WAS CAUSED BY:   |  | IMMEDIATE CAUSE (a)  |  | DUE TO, OR AS A CONSEQUENCE OF (b)                                  |  | DUE TO, OR AS A CONSEQUENCE OF (c)      |  |
| 4140  |  |  |  | Acute Pulmonary Edema  |  | Acute Ischemic Heart Disease  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |   |  |
|   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |   |  |
|   |  | HOUR A.M. MONTH DAY YEAR   |  |  |  |   |  |   |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION  |  |   |  |   |  |
| WHILE <input type="checkbox"/> AT WORK NO <input type="checkbox"/> WHILE <input type="checkbox"/> AT WORK   |  |  |  | STREET CITY/TOWN COUNTY STATE  |  |   |  |   |  |
| 22a. I certify that (b) (this hospital) attended the deceased from 19 to 4/6 19 82, that (l) (we) lost saw the deceased pass on above. (If we) did not view the body after death. |  | 22b. SIGNATURE   |  | DEGREE   |  | 22c. DATE SIGNED  |  |   |  |
|   |  |  |  |  |  | 4-7-82  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  |   |  |   |  |
| HOWARD GABER  |  | 5310 OLD COURT RD. (21133)   |  |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION   |  |   |  |
| BURIAL  |  | 4-7-82   |  | HEBREW YOUNG MENS CEM  |  | BALTO. WOODLAWN MD.   |  |   |  |
| 24. FUNERAL DIRECTOR NAME   |  | 24b. DATE REC'D BY REGISTRAR   |  | 24c. REGISTRAR   |  |   |  |   |  |
| SOL LEVINSON & BROS.  |  | APR 15 1982  |  | Charles J. Smith   |  |   |  |   |  |
| 6010 REISTERSTOWN RD, BALTIMORE, MD. (21215)  |  |  |  |  |  |   |  |   |  |

1 5 0 8 0 1 0

OK

APR 12 1962  
JAMES EARL RAY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 6 2 5

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|   |  |   |   |  |  |
|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>ELVA D. GARRETT   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>4 5 '82  |  | 2b. HOUR<br>11:55P<br>M  |
| 3. SEX<br>FEMALE  | 4. RACE<br>WHITE   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>2 2 '33   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>48 <sup>9</sup><br>YRS.                                      |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.                                    |  |  |
| 10. CITY OR TOWN OF DEATH<br>TOWSON   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(GIVE STREET ADDRESS)<br>GBMC-6701 N. CHARLES ST. |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>AT Home                     | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE 13b. COUNTY 13c. CITY OR TOWN<br>MD. BALTO. PARKVILLE  |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br>9103 LAMARZ ROAD  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Malcolm D. HANLY  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MYRTLE L. SWITZER  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no  | (IF YES, GIVE WAR OR DATES)  | 16b. SOCIAL SECURITY NO.<br>215 30 4824   | 17. INFORMANT<br>ADDRESS<br>Family Records  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) UNCL. HERNIATION<br>2019<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) GRAM NEGATIVE SEPSIS, MENINGITIS<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) LOWERED IMMUNITY SEC. TO HODGKINS DISEASE |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>IMMEDIATE<br>DAYS<br>1981  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)                  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>3-10 82   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>4-5 82                                     |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-5 82, to 4-5 82, that (I) (we) lost<br>saw the deceased alive on above, (I) (we) (did) (did not) view the body after death.  |  |   |   |  |  |
| 22b. SIGNATURE<br>Steinberg MD  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |   | 22c. DATE SIGNED<br>4/5/82   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>JOHN STEINBERG, M.D.   |  | 22e. ADDRESS<br>GBMC-6701 N. CHARLES ST.  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  | 23b. DATE<br>4-9-1982  | 23c. NAME OF CEMETERY OR CREMATORY<br>Moreland MmPK   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>PARKVILLE BALTO. MD.                              |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>EVANS FUNERAL CHAPEL  |  | ADDRESS<br>8800 HARFORD RD.   |   | 25a. DATE REC'D. BY REGISTRAR<br>APR 14 1982   | 25b. REGISTRAR'S SIGNATURE<br>James J. Nathan  |

8 5 0 8 0 2 8

DATE: 11-11-77  
TIME: 10:00 AM  
TO: [illegible]  
FROM: [illegible]

RE: [illegible]  
SUBJECT: [illegible]

1-11-77  
1-11-77  
1-11-77

APR 14 1978

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 6 2 6

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |   |  |   |
|--|--|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>MARZIE B. GARRISON</b>   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 12th, 1982</b>  |  | 2b. HOUR<br>A<br><b>7:15</b>                                    |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>June 26, 1904</b>  |  | 6. AGE<br>(IN YEARS LAST BIRTHDAY)<br><b>77</b>                 |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>South Carolina</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Multi-Medical Center</b> | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Sales Mgr.</b>   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Air Condition</b>  |   |
| 13a. STATE<br><b>Md.</b>   | 13b. COUNTY<br><b>Balto City</b>   | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   | 13d. STREET ADDRESS<br><b>1414 Kingsway Rd. 21218</b>  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles C. Garrison</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mamie Rasor</b>   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>212-03-7610</b>  | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Peggy H. Tice-160 Stanmore Rd. 21212</b>  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1: DEATH WAS CAUSED BY:<br><b>1509</b> IMMEDIATE CAUSE (a) <b>Recurrent Carcinoma of The Esophagus</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Since June 81</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |   |  |   |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>6/21st 71 the present.</b>  |  |   |
| 22. I certify that (I) (the hospital) attended the deceased from <b>April 10th 1982</b> to <b>the present</b> , that (I) (we) last saw the deceased alive on <b>April 10th 1982</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |   |  |   |
| 22a. SIGNATURE<br><b>CE Aranaga</b>  | DEGREE<br><b>M.D.</b>  | 22b. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>             | 22c. DATE SIGNED<br><b>4-13-82</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Carlos E. Aranaga, M.D.</b>  |  | 22e. ADDRESS<br><b>1900 Northern Pkwy.</b>  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  | 23b. DATE<br><b>4/14/82</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine Park Cem.</b>   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore</b>   |   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Mitchell-Wiedefeld Home-6500 York Rd. 21212</b>   |  | 25a. DATE REC'D BY REGISTRAR<br><b>APR 16 1982</b>  |  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows only injury, or other traumatic event, the medical examiner must be notified to give

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 6 2 7

REG. NO.

|  |  |  |  |   |   |   |   |  |  |
|--|--|--|--|---|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Hugh M Geiss   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>4 15 82                         |   |   | 2b. HOUR<br>0105 M  |   |  |  |
| 3. SEX<br>M  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>5 20 06   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>75 YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                    |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Arbutus   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1033 Maiden Choice Lane |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Printer                     |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Self-employed   |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>Arbutus  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS<br>1033 Maiden Choice Lane Apt. 2  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Frederick W. Geiss   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Sarah Mickle          |   |   |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WW II   |  | 17. INFORMANT<br>Elizabeth B. Geiss   |   | ADDRESS<br>1033 Maiden Choice Lane  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u><br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Arteriosclerotic heart disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Arteriosclerosis</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>8 yrs |  |  |  |   |   |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Arteriosclerotic Cerebrovascular disease</u>   |  |  |  |   |   |   |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 <u>75</u> to <u>4/15</u> 19 <u>82</u> that (I) (we) last saw the deceased alive on <u>4/19</u> 19 <u>82</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) know the body after death.   |  |  |  |   |   |   |   |  |  |
| 22b. SIGNATURE<br><u>[Signature]</u>   |  |  |  |   |   | DEGREE  |   | 22c. DATE SIGNED<br>4/15/82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ASTH  |  |  |  |   |   | 22e. ADDRESS<br>206 S. ... St.  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Entombment   |  |  | 23b. DATE<br>04-19-82  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore City Maryland |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Hubbard Funeral Home, Inc.   |  |  |  |   |   | ADDRESS<br>4107 Wilkens Ave.  |   | 25a. DATE REC'D. BY REGISTRAR 25. REGISTRAR'S SIGNATURE<br>APR 16 1982 <u>[Signature]</u>                                  |  |

15680-8

APR 18 1985

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 6 2 8

REG. NO.

|   |  |   |   |   |                              |  |
|---|--|---|---|---|------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>WILLIAM JAMES GEORGIUS SR.</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4-20-82</b> |   | 2b. HOUR<br><b>1:05 P.M.</b> |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>03 13 15</b>   |                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 6. AGE (IN YEARS (LAST BIRTHDAY))<br>IF UNDER 1 YEAR IF UNDER 24 HRS.<br>MONTHS DAYS HOURS MIN.<br><b>67 YRS.</b> |                              |  |
| 10. CITY OR TOWN OF DEATH<br><b>CATONSVILLE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SHADY NOOK NURSING &amp; CONV. HOME</b> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY MD.</b>   |                              |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>LINOTYPE OPERATOR</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>NEWSPAPER</b>   |   |   |                              |  |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>BALTIMORE</b>   |   | 13c. CITY OR TOWN<br><b>ARBUTUS</b>   |                              |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JOSEPH GEORGIUS</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MAMIE GRACE FLORA</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                   |                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>220-05-2704</b>  |   | 17. INFORMANT ADDRESS<br><b>DOROTHY A. GEORGIUS 1160 LINDEN AVE.</b>  |                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Aspiration pneumonia</u><br><b>3310</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last<br>(b) <u>Alzheimer's Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Parkinson's Disease</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>1 year</u><br><u>2 yrs.</u><br><u>2 yrs.</u> |  |   |   |   |                              |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Obstructive disease</u>   |  |   |   |   |                              |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                              |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                              |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  | 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |                              |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |   |   |                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>March 19, 1981</u> to <u>April 20, 1982</u> , that (I) (we) lost<br>saw the deceased alive on <u>April 20, 1982</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |   |   |   |                              |  |
| 22b. SIGNATURE<br><u>Daniel R. Muscarella, M.D.</u>   |  | DEGREE<br><u>M.D.</u>   |   | 22c. DATE SIGNED<br><u>4-20-82</u>  |                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Daniel R. Muscarella, M.D.</u>  |  | 22e. ADDRESS<br><u>7713 Leeds Ave Arbutus, Md.</u>  |   |   |                              |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>04-23-82</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GLEN HAVEN MEM. PARK</b>   |                              |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>GLEN BURNIE A.A. MARYLAND</b>  |  |   |   |   |                              |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>HUBBARD FUNERAL HOME, INC.</b>   |  | ADDRESS<br><b>4107 WILKENS AVE.</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 21 1982</b>   |                              |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>Charles J. Smith</u>   |  |   |   |   |                              |  |

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UNITED STATES DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT  
WASHINGTON, D. C. 20250

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 6 2 9

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |   |   |  |
|---|--|--|---|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>ALEXANDRA GIADKOWSKI</b>   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>4-30-82</b>                                    |   | 2b. HOUR<br><b>M</b>   |
| 3 SEX<br><b>FEMALE</b>  | 4 RACE<br><b>WHITE</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5 28 88</b>   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>93</b> YRS.                                      |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>POLAND</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE</b> <b>GT Co.</b> MD.             |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>BALTO</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>2818 LINGANORE AVE</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEMAKER</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>-</b>  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>BALTIMORE</b>  |  |  | 13b. COUNTY<br><b>LIGHT</b>   | 13c. CITY OR TOWN<br><b>2818 LINGANORE</b>                                |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JOSEPH</b> <b>SOBKOTKA</b>  |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>JOSEPHINE</b> <b>SOBKOTKA</b>      |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>-</b>   | 17 INFORMANT<br>ADDRESS<br><b>329 Upper LANDING Rd</b>                                |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Abdominal Carcinomatosis</b><br><b>1952</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>LAUNDRY -</b>   |  |  |   |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)        |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                     |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3-31</b> 19 <b>82</b> to <b>4-13-82</b> and that (I) (we) last saw the deceased alive on <b>4-13-82</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                              |  |  |   |   |  |
| 22b. SIGNATURE<br><b>Thomas Nizewnik</b>  |  | DEGREE   |   | 22c. DATE SIGNED<br><b>5-3-82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>TO NIZENIK</b>  |  | 22e. ADDRESS<br><b>429 S. HESPER ST 21231</b>  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  | 23b. DATE<br><b>5/4/82</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>HOLY ROSARY</b>   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO</b> <b>County</b> <b>MD</b>    | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 3 1982</b>                        |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>KACZKOWSKI FUNERAL HOME 2525 FLEET ST</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>James Van Nuthen</b>  |   |   |  |

The following is a list of the  
 names of the persons who  
 have been appointed to the  
 various committees of the  
 Board of Directors of the  
 City of New York, for the  
 year 1908.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE **8 2 0 8 6 3 0**  
CERTIFICATE OF DEATH

|  |  |   |  |
|--|--|---|--|
| FOR<br>1. STATE<br>REGISTRAR   |  | REG. NO.  |  |
| I. DECEASED NAME<br>(TYPE OR PRINT)<br><b>JOSEPA D. GILL, SR.</b>  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4 7 82</b>  |  |
| 3. SEX<br><b>MALE</b>  |  | 2b. HOUR<br><b>01:05AM</b>  |  |
| 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Sept. 12, 1916</b>   |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>65</b> YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County MD.</b>   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore County General Hospital</b> |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Stock Clerk-Montgomery Wards</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>   |  |
| 13c. CITY OR TOWN<br><b>Woodlawn</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 13e. STREET ADDRESS<br><b>1805 Colonial Road</b>   |  | 13f. ZIP CODE<br><b>21207</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Ellsworth Gill</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Talena Pearl Krickbaum</b>  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>215-09-8138</b>  |  |
| 17. INFORMANT<br><b>Mrs. Florence Gill</b>   |  | 18. ADDRESS OF INFORMANT<br><b>1805 Colonial Road Baltimore, MD. 21207</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ISCHEMIC HEART DISEASE</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <b>CORONARY ARTERY DISEASE</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>CARCINOID, HEPATIC FAILURE, CONGESTIVE HEART FAILURE</b>  |  |   |  |
| 19a. DATE OF OPERATION<br><b>4/1/82</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>RUPTURED APPENDIX</b>  |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  | 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |
| 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (if this hospital) attended the deceased from <b>3/20/1982</b> to <b>4/7/1982</b> , that I (we) last saw the deceased alive on <b>4/7/1982</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |   |  |
| 22b. SIGNATURE<br><b>Chloé Korman Chloé M.B.S.</b>   |  | 22c. DATE SIGNED<br><b>4/7/82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>A.K. CHOPRA</b>  |  | 22e. ADDRESS<br><b>BALTIMORE COUNTY GEN. HOSPITAL<br/>RANDALLSTOWN, MD 21133</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>4-10-82</b>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine Park Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Woodlawn Baltimore, Maryland</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Loring Byers Funeral Directors, Inc.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 8 1982</b>  |  |
| ADDRESS<br><b>8728 Liberty Road Randallstown, MD. 21133</b>  |  | REGISTRAR'S SIGNATURE<br><b>Charles J. [Signature]</b>  |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be continued by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |  |  | 8 2 0 8 6 3 1<br>REG. NO.                              |  |  |  |                 |  |
|---|--|---|--|---|--|---|--|--|--|--|--|--|--|-----------------|--|
| 1. FOR STATE REGISTRAR  |  |   |  |   |  |   |  |  |  | 2a. DATE OF DEATH                                      |  |  |  | 2b. HOUR        |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>MARGARET M. GILMORE  |  |   |  |   |  |   |  |  |  | 4-26-82  |  |  |  | 6 <sup>PM</sup> |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>2 28 99   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>83 YRS                                     |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS<br>HOURS MIN.                          |  |  |  |                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>NEW YORK   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE County, MD.                 |  |  |  |  |  |  |  |                 |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>STELLA MARIS Hospice |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home  |  |  |  |  |  |                 |  |
| 13a. STATE<br>Maryland  |  |   |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY<br>Towson   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  | 13e. STREET ADDRESS<br>204 E. JOPPA RD Towson MD 21204 |  |  |  |                 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John J. TRAVERS   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Maggie Marrey MAGUIRE  |  |   |  |  |  |  |  |  |  |                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>214-46-7571  |  | 17. INFORMANT<br>ADDRESS<br>STELLA MARIS HOSPICE Dulaney Valley Rd 21204  |  |   |  |  |  |  |  |  |  |                 |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION<br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) CARDIO ARTERIOSCLEROTIC VASCULAR DISEASE<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH           |  |  |  |                 |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  |  |   |  |   |  |   |  |  |  |  |  |  |  |                 |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>     |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |  |                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |  |  |  |  |                 |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |  |  |  |  |                 |  |
| 22a. I certify that (I) (this hospital) attended the deceased from OCTOBER 19 80 to APRIL 19 82, that (I) (we) last saw the deceased alive on 4/19/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |   |  |  |  |  |  |  |  |                 |  |
| 22b. SIGNATURE<br>EDDIE NAKHODA   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |   |  | 22c. DATE SIGNED<br>4/26/82  |  |  |  |  |  |                 |  |
| 23a. PHYSICIAN'S NAME (TYPE OR PRINT)<br>EDDIE NAKHODA  |  |   |  | 23b. ADDRESS<br>STELLA MARIS HOSPICE  |  |   |  |  |  |  |  |  |  |                 |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>April 29, 1982   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Dulaney Valley Cem.   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Cockeysville Balto., Md.        |  |  |  |  |  |  |  |                 |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Ruck Towson Funeral Home, Inc. Towson, Maryland 21204   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>APR 27 1982  |  | 25b. REGISTRAR'S SIGNATURE<br>James J. Kather                                 |  |  |  |  |  |  |  |                 |  |

MEDICAL CERTIFICATION

1 3 0 8 0 1 0

Office of the

City of New York

Department of the City

Record

Volume 111111

1.

Serial 111111, Volume 111111, City of New York, Department of the City

Serial 111111, Volume 111111, City of New York, Department of the City

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be contacted at 1-800-338-1111.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |   |  |  |  |   |   |   | 8 2 0 8 6 3 2                                |                  |  |  |
|--|--|--|---|--|--|--|---|---|---|--|------------------|--|--|
| 1 - FOR STATE REGISTRAR  |  |  |   |  |  |  |   |   |   | REG. NO.                                     |                  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  |   |  | 2a. DATE OF DEATH  |  |   |   |   | 2b. HOUR                                     |                  |  |  |
| FRANK MAURO GIORDANO   |  |  |   |  | April 2, 1982  |  |   |   |   | 2:42a M                                      |                  |  |  |
| 3. SEX   |  | 4. RACE  |   | 5. DATE OF BIRTH   |  |  | 6. AGE (IN YEARS (LAST BIRTHDAY))   |   | IF UNDER 1 YEAR   |  | IF UNDER 24 HRS. |  |  |
| Male   |  | White  |   | Feb 2, 1901  |  |  | 81 YRS.   |   | MONTHS  |  | DAYS             |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |   |   |  |                  |  |  |
| Italy  |  | U.S.A.   |   |  |  |  | Baltimore County MD.  |   |   |  |                  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                     |   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |                  |  |  |
| Rossville  |  | Franklin Square Hospital   |   |  |  |  | Retired Baker   |   | Self Employed   |  |                  |  |  |
| 13a. STATE   |  | 13b. COUNTY  |   | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS   |   |  |                  |  |  |
| Maryland   |  | Baltimore  |   | Rosedale   |  |  |   | 1510 National Road  |   |  |                  |  |  |
| 14. FATHER'S NAME  |  |  |   |  | 15. MOTHER'S MAIDEN NAME   |  |   |   |   |  |                  |  |  |
| John Giordano  |  |  |   |  | Anna ?   |  |   |   |   |  |                  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT  |  |  |   | ADDRESS   |   |  |                  |  |  |
| No   |  | 214-20-6361  |   | Christopher M Giordano   |  |  |   | Same  |   |  |                  |  |  |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)   |  |  |   |  |  |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                  |  |  |
| 4100 Acute Posterior Myocardial Infarction with Left Ventricular Rupture   |  |  |   |  |  |  |   |   |   |  |                  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |   |  |  |  |   |   |   |  |                  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b)   |  |  |   |  |  |  |   |   |   |  |                  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |   |  |  |  |   |   |   |  |                  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:   |  |  |   |  |  |  |   |   |   |  |                  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |  |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                        |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |   |   |  |                  |  |  |
|  |  |  | P.M. 19   |  |  |  |   |   |   |  |                  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION STREET   |  | CITY OR TOWN  |   | COUNTY  |  | STATE            |  |  |
|  |  |  |   |  |  |  |   |   |   |  |                  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 31 19 82, to April 2 19 82, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on April 2 19 82, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. |  |  |   |  |  |  |   |   |   |  |                  |  |  |
| 22b. SIGNATURE   |  |  |   |  | DEGREE   |  |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED                             |                  |  |  |
| Dr. Rothbaum   |  |  |   |  |  |  |   |   |   | 4-2-82                                       |                  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |   |  | 22e. ADDRESS   |  |   |   |   |  |                  |  |  |
| Dr. Rothbaum   |  |  |   |  | 9000 Franklin Square Drive 21237   |  |   |   |   |  |                  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE   |   |  |                  |  |  |
| Burial   |  |  | 4/5/82  |  | Holy Redeemer  |  |   | Baltimore, Maryland   |   |  |                  |  |  |
| 24. FUNERAL DIRECTOR NAME  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR  |  |   | 25b. REGISTRAR'S SIGNATURE  |   |  |                  |  |  |
| Leonard J Ruck Inc. Baltimore, Maryland  |  |  |   |  | APR 2 1982   |  |   | Frances Jean Nathan   |   |  |                  |  |  |

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Item 5 g567 5/4/82 gj

1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 6 3 3

REG. NO.

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST MIDDLE LAST   |  | 2a DATE OF DEATH MONTH DAY YEAR   |  | 2b HOUR   |  |
| JOHN   |  | GIVENS  |  | 4 27 82   |  | 4:45A   |  |
| 3. SEX   | 4. RACE  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  | IF UNDER 1 YEAR   |  |
| MALE   | Black  | 4 8 27 82   |  | 81 YRS.   |  | IF UNDER 24 HRS   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b CITIZEN OF WHAT COUNTRY?  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH   |  |   |  |
| Petersburg, Va.  | USA  |   |  | BALTIMORE COUNTY  |  | MD.   |  |
| 10 CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                  |  | 12b KIND OF BUSINESS OR INDUSTRY                                    |  |
| TOWSON   | GBMC-6701 N. CHARLES ST.   |   |  |   |  |   |  |
| 13a STATE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13b COUNTY  |  | 13c CITY OR TOWN  |  | 13d INSIDE CITY LIMITS?   |  |
| Md.  |  | BALTO.  |  | Balto.  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14 FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME  |  | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)              |  | 16b SOCIAL SECURITY NO.   |  |
| Miles  |  | Elizabeth   |  | No  |  | 66-01-3745  |  |
| 17. INFORMANT  |  | ADDRESS   |  | 17. INFORMANT   |  | ADDRESS   |  |
| Elise Givens   |  | 1008 Beaver Dam Rd.   |  | Elise Givens  |  | 1008 Beaver Dam Rd.   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY:   |  |   |  | Cockeysville, Md. 21030   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |  |
| 4289 IMMEDIATE CAUSE (a) HEART FAILURE   |  |   |  |   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |   |  |   |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |   |  |   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |   |  |   |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  |  |   |  |   |  |   |  |
| 19a DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a AUTOPSY?  |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?       |  |
|  |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |
|  |  | P.M. 19   |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                |  |   |  |
|  |  |   |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-07 19 82 to 4-27 19 82, that (I) (we) last saw the deceased alive on 4-27 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |
| 22b. SIGNATURE   |  | DEGREE  |  | 22c. DATE SIGNED  |  |   |  |
| GARY R. GAFFNEY, M.D.  |  | MD  |  | 4-27-82   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS  |  |   |  |   |  |
| GARY R. GAFFNEY, M.D.  |  | GBMC-6701 N. CHARLES ST.  |  |   |  |   |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION   |  |
| Burial   |  | 4/30/82   |  | STEVENSON A.M.E. CHURCH   |  | SPARKS, MD. STATE   |  |
| 24 FUNERAL DIRECTOR NAME   |  | 24b. ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |
| Leroy O. Dye   |  | 4600 Liberty Hgts   |  | APR 28 1982   |  | James J. Smith  |  |

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11. *Chilivertus* sp.

211. 10/11/1911

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |  |  | 8 2 0 8 6 3 4  |  |
|---|--|--|--|---|--|--|--|--|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | REG. NO.   |  |   |  |  |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Lucia Godwin</b>  |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4 2 82</b>                                 |  | 2b. HOUR<br><b>5:45A M</b>   |  |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>July 25 1875</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>106</b> YRS.                                   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County MD</b>                   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>103 C Dumbarton Rd 21212</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>   |  |  |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles Frank Godwin</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Wilhelmina</b>  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | (IF YES, GIVE WAR OR DATES)  |  | 16b. SOCIAL SECURITY NO.<br><b>216-46-4545</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Wilhelmina Godwin 103C Dumbarton Rd 21212</b>         |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY<br><b>4292</b> IMMEDIATE CAUSE (a) <b>arteriosclerotic C-V disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10+ yrs.</b>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |  |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1970</b> to <b>4-2</b> , 19 <b>82</b> , that (I) (we) lost<br>saw the deceased alive on <b>Nov 19 1981</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                                  |  |  |  |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Frederick J. Vollmer, M.D.</b>   |  |  |  |   |  | DEGREE<br><b>M.D.</b>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>4-2-82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Frederick J. Vollmer</b>  |  |  |  |   |  | 22e. ADDRESS<br><b>6100 York Rd 21212</b>  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>  |  | 23b. DATE<br><b>4-3-82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Greenmount</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore ----- Maryland</b>        |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Mitchell-Wiedefeld Home 6500 York Rd 21212</b>   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 6 1982</b>                                   |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  |  |  |  |  |  | 7 2 0 8 6 3 5  |  |  |  |
|---|--|---|--|--|--|--|--|--|--|--|--|--|--|
| 1 - FOR STATE REGISTRAR   |  |   |  |  |  |  |  |  |  | REG. NO.   |  |  |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Elizabeth GOLLERY</b>   |  |   |  |  |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 13, 1982</b>                          |  |  |  | 2b HOUR<br><b>8:35 P.M.</b>  |  |  |  |
| 3 SEX<br><b>Female</b>  |  | 4 RACE<br><b>White</b>  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2-27-1884</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>98</b> YRS.                                     |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  | IF UNDER 24 HRS.   |  |  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Balto. Md.</b>   |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                   |  |  |  |  |  |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Rossville</b>  |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Square Hospital</b> |  |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Home Maker</b> |  | 12b KIND OF BUSINESS OR INDUSTRY   |  |  |  |  |  |
| 13a STATE<br><b>Md.</b>   |  |   |  |  |  | 13b COUNTY<br><b>Balto.</b>  |  | 13c CITY OR TOWN<br><b>White Marsh</b>   |  | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Wilhelm Kohler</b>  |  |   |  |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Louise Hill</b>                   |  |  |  |  |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b SOCIAL SECURITY NO.<br><b>214-74-3884</b>   |  | 17 INFORMANT<br>ADDRESS<br><b>Mrs. Elizabeth L. Szeliga White Marsh, Md.</b>   |  |  |  |  |  |  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Sepsis secondary to Pneumonia</b>  |  |   |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |
| 4860<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  |  |   |  |  |  |  |  |  |  | (b) <b>Complicated by Congestive Heart Failure</b>   |  |  |  |
|   |  |   |  |  |  |  |  |  |  | (c) <b>And Urinary Tract Infection</b>   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)  |  |   |  |  |  |  |  |  |  |  |  |  |  |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                  |  |  |  |  |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |  |  |  |  |  |  |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |  |  |  |
| 22 I certify that (a) (this hospital) attended the deceased from <b>April 13</b> 19 <b>82</b> , to <b>April 13</b> 19 <b>82</b> , that (x) (we) lost<br>saw the deceased alive on <b>April 13</b> 19 <b>82</b> and that in (x) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (b) (we) (did) (did not) view the body after death. |  |   |  |  |  |  |  |  |  |  |  |  |  |
| 22a SIGNATURE<br><b>Irving Cohen, MD</b>  |  |   |  |  |  | DEGREE<br><b>M.D.</b>  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c DATE SIGNED<br><b>4/13/82</b>  |  |  |  |
| 22b PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Irving Cohen, MD</b>   |  |   |  |  |  | 22e ADDRESS<br><b>9000 Franklin Sq. Drive, Balto, MD 21237</b>                       |  |  |  |  |  |  |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b DATE<br><b>4-16-82</b>  |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>Pinkwood Cem.</b>  |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. Md.</b>                       |  |  |  |  |  |  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>John C. Miller Inc-6415 Belair Rd.-21206</b>  |  |   |  |  |  | ADDRESS<br><b>APR 19 1982</b>  |  | 25a DATE REC'D. BY REGISTRAR   |  | 25b REGISTRAR'S SIGNATURE<br><b>Rene J. Smith</b>  |  |  |  |

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U.S. AIR FORCE

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*[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page.]*

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U.S. AIR FORCE

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. It is to be retained by the hospital or attending physician.

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FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 6 3 6

REG. NO.

|   |  |   |  |  |                                      |  |
|---|--|---|--|--|--------------------------------------|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>HARRY Gordon</b>  |  |   | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>4 19 82</b> |  | 2b HOUR<br><b>10<sup>40</sup> AM</b> |  |
| 3 SEX<br><b>m</b>   |  | 4 RACE<br><b>W</b>  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4 15 90</b>  |                                      |  |
| 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>92</b> YRS   |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS<br>HOURS MIN.  |                                      |  |
| 7 BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                      |  |
| 9 CITY OR TOWN OF DEATH<br><b>Cockeysville</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Md Masonic Home</b> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore Co.</b> MD.  |                                      |  |
| 10 USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>10a. STATE <b>md</b> 10b. COUNTY <b>MD</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                                      |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles Gordon</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Eva 7</b>   |  | 13e. STREET ADDRESS<br><b>3611 Delverne Rd</b>   |                                      |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b SOCIAL SECURITY NO.<br><b>216-28-9284</b>   |  | 17 INFORMANT ADDRESS<br><b>MARYLAND MASONIC HOME COCKEYSVILLE, MD.</b>   |                                      |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>HEART FAILURE</b><br><b>4141</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>FAILURE OF LEFT VENTRICLE</b> ?<br>(c) <b>ACUTE SEVERE AORTIC STENOSIS</b> ?<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3-11-82</b> |  |   |  |  |                                      |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |  |   |  |  |                                      |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |                                      |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |                                      |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>3/14/82</b> 19____, to <b>4/19/82</b> 19____, that (I) (we) last saw the deceased alive on <b>3/19/82</b> 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |  |                                      |  |
| 22b. SIGNATURE<br><b>Walter E. Karfoin</b>  |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>4/21/82</b>   |                                      |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>WALTER E. KARFOIN M.D.</b>  |  | 22e. ADDRESS<br><b>COCKEYSVILLE, MD. 21030</b>  |  |  |                                      |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>4/22/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>PARKWOOD</b>  |                                      |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>PARKVILLE BALTO. CO. MD.</b>   |  | 25. DATE REC'D. BY REGISTRAR<br><b>APR 23 1982</b>  |  |  |                                      |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>MITCHELL - WIEDEFFELD HOME</b>  |  | ADDRESS<br><b>6500 YORK RD BALTO. MD 21212</b>  |  |  |                                      |  |



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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 2 0 8 6 3 7  
REG. NO.

|  |  |  |  |   |                                       |  |  |
|--|--|--|--|---|---------------------------------------|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Lucille C Gordon</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4-3-82</b> |   | 2b. HOUR<br><b>7:45<sup>a</sup> M</b> |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 24 05</b>  |                                       | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>76</b><br>YRS. MONTHS DAYS<br>IF UNDER 1 YEAR<br>IF UNDER 24 HRS.<br>HOURS MIN.      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Georgia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                       | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b><br>MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto., Md.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Stella Maris Hospice</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Cook/Housekeeper</b>   |                                       | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b><br>13b. COUNTY<br><b>Baltimore</b>   |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                                       | 13e. STREET ADDRESS<br><b>Blessed Sacrament Res./Mercy</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Gordon</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Rebecca Allen</b>   |                                       |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>225-40-5544</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Sister Mary Thomas Mercy Hosp.<br/>Stella Maris Hospice, Dulaney Valley Rd.</b>  |                                       |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Malignant Lymphoma</b><br><b>2028</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |   |                                       | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>101 days</b>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |                                       |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |                                       |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                                       |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/22/82</b> 19 <b>82</b> , to <b>4-3</b> 19 <b>82</b> , that (I) (we) lost<br>saw the deceased alive on <b>4-3</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                  |  |  |  |   |                                       |  |  |
| 22b. SIGNATURE<br><b>Eddie Nakhuda, M.D.</b><br>DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  |  |  |   |                                       | 22c. DATE SIGNED<br><b>4-3-82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Eddie Nakhuda, M.D.</b>  |  |  |  | 22e. ADDRESS<br><b>Stella Maris Hospice, Dulaney Valley Road</b>  |                                       |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>4/7/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn Cem.</b>  |                                       | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co. MD</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H</b>  |  |  |  | ADDRESS<br><b>1101 E. North Ave.</b>  |                                       | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 5 1982</b><br>REGISTRAR'S SIGNATURE<br><i>James J. Martin</i>                      |  |

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Item #1 per phone call w/Fun. Home STATE OF MARYLAND

FOR  
1- STATE  
REGISTRAR  
4/14/82 rcDEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 08638

|  |                  |   |  |  |  |   |  |  |  |   |  |                        |  |
|--|------------------|---|--|--|--|---|--|--|--|---|--|------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |                  | FIRST<br>Norman   |  | MIDDLE<br>Leroy  |  | LAST<br>Gordon  |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED               |  | MONTH DAY YEAR<br>4 9 19 82                             |  | 2b. HOUR<br>M<br>7:42P |  |
| 3. SEX<br>Male   | 4. RACE<br>White | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>March 12, 1925  |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br>57 YRS.  |  | IF UNDER 1 YR.<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.                     |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>4 9 19 82 |  | 2d. HOUR<br>M          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                        |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED<br>WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.              |  |  |  |   |  |                        |  |
| 10. CITY OR TOWN OF DEATH<br>Reisterstown                                    |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>14828 Dover Rd. |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Engineer |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Telephone Co. |  |   |  |                        |  |
| 13a. STATE<br>Md.  |                  |   |  | 13b. COUNTY<br>Balto.  |  | 13c. CITY OR TOWN<br>Reisterstown   |  | 13d. STREET ADDRESS<br>213 Delight Road            |  |   |  |                        |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Leroy B. Gordon                    |                  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>IRene   |  |   |  |  |  |   |  |                        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>Yes |                  |   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WW II   |  | 17. INFORMANT<br>Kathryn Hoke   |  | 6 I Trolld Court<br>Owings Mills, Md.              |  |   |  |                        |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I DEATH WAS CAUSED BY:

9651

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

IMMEDIATE CAUSE (a) Shotgun wounds of head and chest

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.

MEDICAL CERTIFICATION

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                    |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>           |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  | 21b. TIME OF INJURY<br>HOUR AM MONTH DAY YEAR<br>7:20 AM 4 9 19 82   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>Subject shot |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>house |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>14828 Dover Rd. Reisterstown P.G. Md.    |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> and in my opinion |  |  |  |   |  |
| ACTUAL SIGNATURE<br><i>Thomas D. Smith</i>  |  | TITLE (SPECIFY)<br>M.D. Deputy Chief                                 |  | DATE SIGNED<br>4/10/82  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Thomas D. Smith, M.D.   |  | ADDRESS<br>111 Penn St. Balto., MD.                                  |  |   |  |

|  |                            |  |  |
|--|----------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial | 23b. DATE<br>Apr. 13, 1982 | 23c. NAME OF CEMETERY OR CREMATORY<br>Deer Park Cemetery | 23d. LOCATION<br>COUNTY<br>Shallwood, Carroll Co., Md. |
|--|----------------------------|--|--|

|  |                                   |  |   |
|--|-----------------------------------|--|---|
| 24. FUNERAL DIRECTOR<br><i>Edhardt</i> | ADDRESS<br>Owings Mills, Maryland | 25a. DATE REC'D. BY REGISTRAR<br>APR 13 1982 | 25b. REGISTRAR'S SIGNATURE<br><i>Frances Jan Nathan</i> |
|--|-----------------------------------|--|---|

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Department of Health.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 6 3 9

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|   |  |   |  |   |   |
|---|--|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Raymond Earl Gordon</i>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>April 26, 1982</i>               |   | 2b. HOUR<br>MIN.<br><i>7:00P</i>  |
| 3. SEX<br><i>Male</i>   | 4. RACE<br><i>White</i>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>March 2, 1905</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><i>77</i>                                      |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>West Virginia</i>   | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore County</i> MD.                                   |   |
| 10. CITY OR TOWN OF DEATH<br><i>Randallstown</i>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Randallstown Convalescent Center</i> |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Machinist General Electric</i> |   |
| 13a. STATE<br><i>Maryland</i>   |  |   | 13b. COUNTY<br><i>Carroll</i>  | 13c. CITY OR TOWN<br><i>Sykesville</i>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Bennett H. Gordon</i>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Mary Jane Allender</i> |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><i>214-03-3703A</i>  |  | 17. INFORMANT<br>NAME ADDRESS<br><i>Mr. Orvis D. Mills<br/>155 Maricopa St. Enon, Ohio 45323</i>      |   |
| 18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><i>1629</i> IMMEDIATE CAUSE (a) <i>Cardio Respiratory failure.</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <i>Advanced Ca Lung (C).</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>ASCVD, Arterial fib, CBF</i> |  |   |  |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |  |   |  |   |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                             |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                        |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>4-56</i> 19 <i>82</i> to <i>4-26</i> 19 <i>82</i> , that (I) (we) lost<br>saw the deceased alive on <i>4-56</i> 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |   |
| 22b. SIGNATURE<br><i>[Signature]</i>  |  |   |  | 22c. DATE SIGNED<br><i>4-27-82</i>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Babu Y. Rao</i>   |  |   |  | 22e. ADDRESS<br><i>8811 Liberty Rd. 21133</i>   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>   |  | 23b. DATE<br><i>4/29/82</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Lake View Memorial</i>                                       |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Eldersburg Carroll Md</i>  |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><i>8728 Liberty Rd. Randallstown, Md.<br/>Loring Byers Funeral Directors, Inc. 21133</i>                            |  |   |   |
| 25a. DATE REC'D. BY REGISTRAR<br><i>APR 27 1982</i>   |  | 25b. REGISTRAR SIGNATURE<br><i>[Signature]</i>  |  |   |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |  |  | 8 2 0 8 6 4 0 |  |
|---|--|---|--|---|--|---|--|--|--|---------------|--|
| 1- FOR<br>STATE<br>REGISTRAR  |  | REG. NO.  |  |   |  |   |  |  |  |               |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>BESSIE FRANCES GOSNELL</b>   |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 12<sup>th</sup> 1982</b> |   |  | 2b. HOUR<br><b>7P.</b>   |  |               |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9 9 1892</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>89</b>  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |               |  |
| 8. BIRTHPLACE<br>(COUNTRY) STATE OR FOREIGN<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                             |  |  |  |               |  |
| 10. CITY OR TOWN OF DEATH<br><b>Pikesville</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Pikesville Nursing Home</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>----</b>   |  |               |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>A.A. Co.</b>  |  | 13c. CITY OR TOWN<br><b>Linthicum</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>212 Hammond Ferry Road 21090</b>   |  |               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Walter Warfield</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Frances Day</b>   |  |   |  |   |  |  |  |               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>216-88-9098</b>   |  | 17. INFORMANT ADDRESS<br><b>Doris M. Bullen 16 Eleanor Avenue 21090</b>   |  |   |  |  |  |               |  |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Lymphoma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Arteriosclerotic CVD, advanced</b> |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>(yes)</b>   |  |               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |  |   |  |   |  |   |  |  |  |               |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |               |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |               |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/19 1981</b> to <b>4/12 1982</b> that (I) (we) lost <b>4/12 1982</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did not view the body after death.  |  |   |  |   |  |   |  |  |  |               |  |
| 22b. SIGNATURE<br><b>Herbert V. Levickas MD</b>   |  |   |  | 22c. DATE SIGNED<br><b>4/13/82</b>  |  | 22d. ADDRESS<br><b>5404 East Drive (21227)</b>  |  |  |  |               |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>4/15/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>                         |  |  |  |               |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 14 1982</b>   |  |   |  |  |  |               |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles J. [Signature]</b>   |  |   |  |   |  |   |  |  |  |               |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 8 2 0 8 6 4 1<br>REG. NO.  |  |  |  |   |  |  |  |   |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|---|--|--|--|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  | 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>ROSALINE GRAVES</b>  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>4 09 82</b>  |  |  |  | 2b. HOUR<br><b>2:00 AM</b>  |  |  |  |  |  |  |  |
| 3. SEX<br><b>FEMALE</b>  |  |  |  | 4. RACE<br><b>White</b>  |  |  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 19 18</b>   |  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>63</b>  |  |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New York</b>   |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY MD.</b>   |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON, MD</b>   |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>GBMC-6701 N. CHARLES ST.</b> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Controller</b>   |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Law firm</b>  |  |  |  |  |  |  |  |
| 13a. STATE<br><b>Md.</b>   |  |  |  | 13b. COUNTY<br><b>Balto</b>  |  |  |  | 13c. CITY OR TOWN<br><b>Lutherville</b>   |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  | 13e. STREET ADDRESS<br><b>8211 Whitemanor Drive</b>              |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Mack Gutzert</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Pauline Kiken</b>  |  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>084-03-9606</b>  |  |  |  | 17. INFORMANT<br>ADDRESS<br><b>Anne Denmark Lutherville, Md.</b> |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>1629 IMMEDIATE CAUSE (a) CARDIO RESPIRATORY ARREST</b>   |  |  |  |  |  |  |  |   |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CARCINOMA OF THE LUNG</b>   |  |  |  |  |  |  |  |   |  |  |  |   |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |  |  |  |  |  |  |   |  |  |  |   |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>C N S METASTASTS</b>   |  |  |  |  |  |  |  |   |  |  |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)  |  |  |  |   |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>3/01 82 4/09 82</b>   |  |  |  | 21g. <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>4/09 82</b> , to <b>4/09 82</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on above, (I) <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> view the body after death, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated |  |  |  |  |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>4/09 82</b> , to <b>4/09 82</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on above, (I) <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> view the body after death, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated |  |  |  | 22b. SIGNATURE<br><b>Karl I. Lanocha MD</b>  |  |  |  | DEGREE<br><b>MD</b>   |  |  |  | 22c. DATE SIGNED<br><b>4/09/82</b>  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>KARL I. LANOCHA, MD</b>  |  |  |  | 22e. ADDRESS<br><b>GBMC-6701 N. CHARLES ST.</b>  |  |  |  |   |  |  |  |   |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Removal</b>   |  |  |  | 23b. DATE<br><b>4/9/82</b>   |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Anatomy Board</b>   |  |  |  | ADDRESS<br><b>Balto., Md.</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 15 1982</b>   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Thane J. [Signature]</i>   |  |  |  |  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

|   |  |  |   |  |                                   |  |                     |  |                   |   |                   |
|---|--|--|---|--|-----------------------------------|--|---------------------|--|-------------------|---|-------------------|
| 1. FOR STATE REGISTRAR  |  | DECEASED NAME<br>(TYPE OR PRINT)   |   | FIRST  | MIDDLE                            | LAST   | 2a. DATE OF DEATH   | MONTH  | DAY               | YEAR  | 2b. TIME OF DEATH |
|   |  | ROSE   |   |  |                                   | GREENBERG  | APRIL 27, 1982      |  |                   |   | 5:35 A.M.         |
| 3. SEX  | 4. RACE  | 5. DATE OF BIRTH   |   | 6. AGE (IN YEARS LAST BIRTHDAY)  |                                   | 7. BALTIMORE CITY OR COUNTY OF DEATH                           |                     | 8. IF UNDER 1 YEAR   |                   | 8. IF UNDER 24 HRS.   |                   |
| FEMALE  | WHITE  | MAR. 17, 1914  |   | 68 YRS.  |                                   | BALTIMORE COUNTY   |                     | MONTHS   |                   | DAYS  |                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH   |                                   | 10. BALTIMORE COUNTY   |                     | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)   |                   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |                   |
| RUSSIA  | USA  |  |   |  |                                   |  |                     | BALTIMORE COUNTY GEN. HOSP.  |                   | SECRETARY   |                   |
| 13. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY |  | 13a. STREET ADDRESS |  | 13b. CITY OR TOWN |   | 13c. STATE        |
| RANDALLSTOWN  | BALTIMORE COUNTY GEN. HOSP.  |  | SECRETARY   |  | OFFICE                            |  | 3812 GLENGYLE AVE.  |  | BALTO., MD        |   | 21215             |
| 14. FATHER'S NAME   | 15. MOTHER'S MAIDEN NAME   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |   | 16b. SOCIAL SECURITY NO.   |                                   | 17. INFORMANT  |                     | 18. CAUSE OF DEATH   |                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                  |                   |
| LOUIS LAIV GREENBERG  | HANNAH DERMAN  | NO   |   |  |                                   | DR. LEAH GREENBERG   |                     | 5609   |                   |   |                   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?  |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                     | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) |                   | 21b. TIME OF INJURY   |                   |
|   |  |  |   | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |                                   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                     |  |                   | HOUR A.M. MONTH DAY YEAR                                      |                   |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                   | 21g. LOCATION  |                     | 21h. CITY OR TOWN  |                   | 21i. STATE  |                   |
| WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>   |  |  |   |  |                                   | STREET   |                     | CITY OR TOWN   |                   | STATE   |                   |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost  |  | 22b. SIGNATURE   |   | DEGREE   |                                   | 22c. DATE SIGNED   |                     | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |                   | 22e. ADDRESS  |                   |
| saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  | Hafeez A Syed  |   |  |                                   | 4/27/82  |                     | HAFAEEZ A SYED M.D.  |                   | BALTIMORE COUNTY GEN HOSP.                                    |                   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY   |                                   | 23d. LOCATION  |                     | 23e. DATE REC'D. BY REGISTRAR  |                   | 23f. REGISTRAR'S SIGNATURE                                    |                   |
| BURIAL  |  | APR. 28, 1982  |   | OHR KNESSETH ISRAEL  |                                   | ANSHE SFARD ROSEDALE BALTO., MD                                |                     | MAY 4 1982   |                   | Frances Santh...  |                   |
| 24. FUNERAL DIRECTOR  |  | 25. DATE REC'D. BY REGISTRAR   |   | 25. REGISTRAR'S SIGNATURE  |                                   | 25. REGISTRAR'S SIGNATURE                                      |                     | 25. REGISTRAR'S SIGNATURE  |                   | 25. REGISTRAR'S SIGNATURE                                     |                   |
| SOL LEVINSON & BROS., INC.  |  | MAY 4 1982   |   | Frances Santh...   |                                   | Frances Santh...   |                     | Frances Santh...   |                   | Frances Santh...  |                   |
| 6010 REISTERSTOWN RD. BALTO., MD  |  |  |   |  |                                   |  |                     |  |                   |   |                   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 6 4 3

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |                         |   |   |   |                                 |  |
|--|-------------------------|---|---|---|---------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>John M. GRUEBLER</b>  |                         |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 1, 1982</b> |   | 2b. HOUR<br>4:15 P <sub>M</sub> |  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>May 29 1896</b>                                |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>85</b>  |                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Baltimore, Md.</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                 |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rossville 21237</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br><b>Franklin Sq. Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OR WORK FOR MOST OF WORKING LIFE)<br><b>Clerk</b>  |                                 |  |
| 13a. STATE<br><b>Maryland</b>  |                         | 13b. CITY OR TOWN<br><b>Baltimore</b>   |   | 13c. STREET ADDRESS<br><b>Essex 21221</b>   |                                 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George Gruebler</b>   |                         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Margaret Moser</b>                  |   | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES OR UNKNOWN) <b>Yes</b>  |                                 |  |
| 17. INFORMANT<br><b>John Hughes</b>  |                         | 18. SOCIAL SECURITY NO.<br><b>1914-21</b>   |   | 19. ADDRESS<br><b>214 12 2054</b>   |                                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiorespiratory arrest</b><br>4275<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF                                |                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |   |   |                                 |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>old age; old cerebrovascular accident; postherpetic neuralgia; diabetes; aspiration</b>   |                         |   |   |   |                                 |  |
| 19a. DATE OF OPERATION   |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                              |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |                                 |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                         | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                                 |  |
| 22a. I certify that (X) (this hospital) attended the deceased from <b>March 11</b> 19 <b>82</b> , to <b>April 1</b> 19 <b>82</b> , that (X) (we) last saw the deceased alive on <b>April 1</b> 19 <b>82</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death. |                         |   |   |   |                                 |  |
| 22b. SIGNATURE<br><b>Golfredo Stuart, MD</b>   |                         | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>4/1/82</b>   |                                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Golfredo Stuart, MD</b>  |                         | 22e. ADDRESS<br><b>9000 Franklin Square Dr., 21237</b>                                  |   |   |                                 |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>Burial</b>   |                         | 23b. DATE<br><b>4/3/82</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood Cemetery</b>  |                                 |  |
| 23d. LOCATION<br><b>Baltimore, Md.</b>   |                         | COUNTY  |   | STATE   |                                 |  |
| 24. FUNERAL DIRECTOR<br><b>Brudzinski Funeral Home PA 1407</b>   |                         | 25a. DATE REC'D BY REGISTRAR<br><b>APR 2 1982</b>                                       |   | 25b. REGISTRAR'S SIGNATURE<br><b>James J. Nathan</b>  |                                 |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 48 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |   |               | 8 2 0 8 6 4 4  |  |
|---|--|---|--|---|--|--|--|---|---------------|--|--|
| 1 - FOR STATE REGISTRAR   |  |   |  |   |  |  |  |   |               | REG. NO.   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>B Elizabeth Gurklis  |  |   |  |   |  | 2a. DATE OF DEATH<br>April 25, 1982  |  |   | 2b. HOUR<br>M |  |  |
| 3 SEX<br>Female   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>October 30, 1921  |  | 6. AGE (IN YEARS (LAST BIRTHDAY))<br>60  |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |               | IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Penna.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County   |  |   | MD.           |  |  |
| 10. CITY OR TOWN OF DEATH<br>Rossville  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Franklin Square Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Secretary  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |               |  |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>BALTO  |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 14. STREET ADDRESS<br>5839 Westwood Ave                                   |               |  |  |
| 14. FATHER'S NAME<br>John W Tait  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>Blanche E Souilliard  |  |  |  |   |               |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES/NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>164-14-2983   |  | 17. INFORMANT ADDRESS<br>Miss Dianne L Grafton 6709 Havenoak Rd   |  |  |  |   |               |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Ventricular tachycardia.</u><br><u>4149</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <u>Coronary heart dis.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |  |   |  |  |  |   |               | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |  |   |  |   |  |  |  |   |               |  |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |               | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |               |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |               |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10-6-81</u> to <u>4-25-82</u> , that (I) (we) lost saw the deceased alive on <u>4-19-82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |   |               |  |  |
| 22b. SIGNATURE<br>Robert Roubenoff M.D.   |  |   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>4-26-82   |               |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Robert Roubenoff M.D.  |  |   |  |   |  | 22e. ADDRESS<br>7652 A Belair Rd. Baltimore, Maryland  |  |   |               |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>4/28/82  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Parkwood  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland  |  |   |               |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Leonard J Ruck Inc. Baltimore, Maryland   |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>APR 27 1982   |  | 25b. REGISTRAR'S SIGNATURE<br>Theresa Van Natten                          |               |  |  |

1-1-80 28

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APR 3 1980

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.10  
FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 6 4 5

REG. NO.

|   |  |   |   |   |  |  |  |
|---|--|---|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Hazel W. Hackett</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4 17 82</b> |   |  | 2b. HOUR<br><b>11:00 P.M.</b>  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 4 08</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Catonsville</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1933 Beverly Road</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>                                       |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>  |  |   |   |   |  |  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   |   | 13c. CITY OR TOWN<br><b>Catonsville</b>   |  | 13d. INSIDE CITY LIMITS<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                             |  |
| 13e. STREET ADDRESS<br><b>1933 Beverly Road</b>   |  | 21228   |   |   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George Weil</b>  |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Helen Allen</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>212-05-2817</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>Rufus W. Hackett Same as # 13</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>4292</b><br>IMMEDIATE CAUSE (a) <b>Alcohol - chronic Carolis Vena Rec.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10 yrs</b> |  |   |   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:<br><b>Chronic Post myocardial Infarction</b>   |  |   |   |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Mar 19 75</b> to <b>4-11-82</b> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <b>6-10-82</b> and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> <input type="checkbox"/> did not view the body after death.                 |  |   |   |   |  |  |  |
| 22b. SIGNATURE<br><b>J. Nelson McKay</b>  |  | DEGREE<br><b>M.D.</b>   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br><b>4/19/82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>J. Nelson McKay M.D.</b>  |  |   |   | 22e. ADDRESS<br><b>1132 N. Rolling Road, Baltimore, Md. 21228</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>4/21/82</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ludon Park Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Witzke P.A.</b>  |  |   |   | ADDRESS<br><b>1630 Edmondson Avenue, Catonsville, Md. 21228</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 20 1982</b>  |  |
|   |  |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Thomas J. Zastner</b>  |  |  |  |

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2 3 4 5 6 7 8 9 10 11 12

TO THE HONORABLE  
MEMBERS OF THE  
HOUSE OF REPRESENTATIVES  
WASHINGTON, D. C.  
JANUARY 10, 1912

100-10-1000

APR 20 1912  
JAMES J. HANCOCK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |   |   |   |  |  | 8 2 0 8 6 4 6<br>REG. NO.                                    |  |  |  |
|--|--|--|--|---|---|---|---|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Maryanne Haines</b>   |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4 13 82</b>   |   |   |  |  | 2b. HOUR<br><b>5:55 A</b>                                    |  |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Caucasian</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 27 04</b>  |   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b> YRS.                   |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                    |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New Oxford, Pa.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore Co.</b> MD.    |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Randall Station</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Old Court Nursing Center</b> |  |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)    |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                            |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Md.</b> 13b. COUNTY <b>Carroll</b> 13c. CITY OR TOWN <b>Finksburg</b>  |  |  |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>2710 Wildorlyn Drive</b>                  |  |  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>McCaifery</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Aghes Clark</b>  |  |   | 17. INFORMANT<br>ADDRESS<br><b>Charles D. Haines 2710 Wildorlyn Drive</b>                       |   |   |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>218-16-0268</b>   |  |   |   |   |   |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pneumonia</b><br><b>4860</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |   |   |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 day</b> |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1c   |  |  |  |   |   |   |   |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |   |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>3-28-81 to 4-13-82</b>  |   |   |   |  |  |  |  |  |  |
| 22a. I certify that (a) (this hospital) attended the deceased from <b>4-12-82</b> to <b>4-13-82</b> , the deceased alive on above, (b) (he) (did) (did not) view the body after death.   |  |  |  |   |   |   |   |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>[Signature]</b>   |  | DEGREE<br><b>MD</b>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |   |   |   | 22c. DATE SIGNED<br><b>4/13/82</b>   |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>P. S. F. Fletcher</b>  |  | 22e. ADDRESS<br><b>5400 Old Court Rd</b>   |  |   |   |   |   |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>4-15-82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Marys Cemetery</b>   |   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>New Oxford Pa.</b> |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Ed Helt</b>   |  | ADDRESS<br><b>254 East Main Street Westminster, Md. 21157</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 16 1982</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Thomas J. [Signature]</b>                |   |  |  |  |  |  |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 2 0 8 6 4 7  
CERTIFICATE OF DEATH

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |   |  |  |   |  |                                    |   |   |  |
|--|--|--|---|--|--|---|--|------------------------------------|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>LYDIA</b>  |  |  | FIRST MIDDLE LAST<br><b>HALL</b>  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>4 23 '82</b>   |  |                                    | 2b. HOUR<br><b>12:10A</b>   |   |  |
| 3. SEX<br><b>FEMALE</b>  |  |  | 4. RACE<br><b>Black</b>   |  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>7 14 '12</b>  |  |                                    | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN.<br><b>69</b>  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>North Carolina</b>   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                                    | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>GBMC-6701 N. CHARLES ST.</b> |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>   |  |                                    | 12b. KIND OF BUSINESS OR INDUSTRY   |   |  |
| 13a. STATE<br><b>Md</b>  |  |  |   |  |  | 13b. COUNTY<br><b>Balto</b>   |  | 13c. CITY OR TOWN<br><b>Towson</b> |   | 13d. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Allen Whittington</b>  |  |  |   |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Alvenia Maddock</b>  |  |                                    |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>212-32-2103A</b>   |  |  | 17. INFORMANT ADDRESS<br><b>Mr. Isaac Hall 421 Jefferson Ave Towson Md 21204</b>  |  |                                    |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio pulmonary arrest</b><br><b>4960</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Chronic obstructive Pulmonary disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <b>Chronic Restrictive Pulmonary disease</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Pneumonia</b> |  |  |   |  |  |   |  |                                    |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |                                    | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |                                    |   |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |                                    |   |   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>March 15, 19 82</b> , to <b>April 23, 19 82</b> that (I) (we) last saw the deceased alive on <b>April 23, 19 82</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.  |  |  |   |  |  |   |  |                                    |   |   |  |
| 22b. SIGNATURE<br><b>Elisa Brown Soltero</b>   |  |  |   |  |  | DEGREE<br><b>MD</b>   |  |                                    | 22c. DATE SIGNED<br><b>April 23, 1982</b>   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ELISA BROWN-SOLTERO</b>  |  |  |   |  |  | 22e. ADDRESS<br><b>GBMC-6701 N. CHARLES ST.</b>   |  |                                    |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>Burial</b>   |  |  | 23b. DATE<br><b>4/27/82</b>   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley Mem</b>   |  |                                    | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Towson Balto. Md.</b>   |   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Chatman F/H</b>  |  |  |   |  |  | ADDRESS<br><b>1701 Mc Culloch St</b>  |  |                                    | 25a. DATE REC'D BY REGISTRAR<br><b>APR 26 1982</b>  |   |  |
|  |  |  |   |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Santhorne</b>  |  |                                    |   |   |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed withing 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  |   |  |   |  |  |  | 8 2 0 8 6 4 8  |  |  |  |
|--|--|---|--|---|--|---|--|--|--|--|--|--|--|
| 1 - FOR STATE REGISTRAR  |  |   |  |   |  |   |  |  |  | REG. NO.   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Lynwood A. Hall, Jr.</b>   |  |   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4 10 82</b>   |  | 2b. HOUR<br>M<br><b></b>   |  |  |  |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4 27 1929</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS.<br><b>52</b>  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b></b>  |  | IF UNDER 24 HRS.<br>HOURS MIN.<br><b></b>  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>West Virginia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County MD</b>                              |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Edgemere</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>2903 Ross Avenue</b> |  |   |  | 12a. OCCUPATION (TYPE OR NATURE OF WORKING LIFE)<br><b>Checker Receiver</b>                     |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Airco Welding</b>  |  |  |  |  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Edgemere</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>2903 Ross Avenue</b>   |  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Lynwood A. Hall, Sr.</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Daisey Atkins</b>   |  |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>Yes</b>  |  |  |  |  |  |
| 16b. SOCIAL SECURITY NO.<br><b>217-20-5528</b>   |  |   |  | 17. INFORMANT<br><b>Gretchel A. Hall</b>  |  |   |  | ADDRESS <b>2903 Ross Avenue Balto., MD. 21219</b>  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Generalized Abdominal Carcinomatosis</b><br><b>1541</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinoma of the rectum</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> |  |   |  |   |  |   |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b></b>  |  |   |  |   |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>S. E. Sibayan M.D.</b>  |  |   |  |   |  | DEGREE<br><b>M.D.</b>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>4-12-82</b>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>SAMUEL E. SIBAYAN, M.D.</b>  |  |   |  |   |  | 22e. ADDRESS<br><b>1012 Old N. Pt. Rd. Balto. Md. 21224</b>                                     |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |   |  | 23b. DATE<br><b>4/13/1982</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Duda-Ruck, Inc.</b>   |  |   |  |   |  | ADDRESS<br><b>7922 Wise Avenue Dundalk, MD. 21222</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 14 1982</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>James J. Nathan</b>   |  |  |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 6 4 9

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Virginia M. Harding  
HARDING VIRGINIA M.

2a. DATE OF DEATH

MONTH

DAY

YEAR

2b. HOUR

M

4-26-82

12-25

3. SEX

female

4. RACE

white

5. DATE OF BIRTH

MONTH

DAY

YEAR

April 13, 1920

6. AGE (IN YEARS LAST BIRTHDAY)

62

YRS.

MONTHS

DAYS

HOURS

MIN.

7a. BIRTHPLACE  
(STATE OR FOREIGN  
COUNTRY)

Maryland

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore County

MD.

10. CITY OR TOWN OF DEATH

Randallstown

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION  
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Baltimore County General

12a. USUAL OCCUPATION  
(TYPE OF WORK FOR MOST OF WORKING LIFE)

Housewife

12b. KIND OF BUSINESS OR  
INDUSTRY

own home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

Baltimore

13c. CITY OR TOWN

Catonsville

13d. INSIDE CITY LIMITS?

YES ☒NO ☐

13e. STREET ADDRESS

2 Marathon Drive

14. FATHER'S NAME

FIRST

MIDDLE

LAST

Arthur B. Veit, Sr.

15. MOTHER'S MAIDEN NAME

FIRST

MIDDLE

LAST

Marion D. Harboch

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(YES, NO OR UNKNOWN)  
(IF YES, GIVE WAR OR DATES)

no

16b. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mr. Henry R. Harding, Jr. 2 Marathon Drive

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardio-pulmonary arrest 20

4360  
Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) TO urmic with Cardiac arrhythmia.

DUE TO, OR AS A CONSEQUENCE OF

(c) 20 to Cerebro-Vascular Accident.

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

MEDICAL CERTIFICATION

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒20b. IF YES, WERE FINDINGS USED  
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐  
AT WORK AT WORK21e. PLACE OF INJURY  
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)21f. LOCATION  
STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 4-15-1982, to 4-26-1982, that (I) (we) last  
saw the deceased alive on 4-26-1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated  
above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

R.M. Shah, M.D.

DEGREE

ATTENDING ☒ MEDICAL ☐ STAFF  
PHYSICIAN DIRECTOR PHYSICIAN

22c. DATE SIGNED

4/26/82

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

R.M. SHAH.

22e. ADDRESS

4360 B.C.G.H. OLD COURT RD.  
RANDALLSTOWN, MD. 21784.23a. BURIAL, CREMATION, REMOVAL  
(SPECIFY)

Entombment

23b. DATE

4/29/82

23c. NAME OF CEMETERY OR CREMATORY

Loudon Park Mausoleum

23d. LOCATION  
CITY OR TOWN

Baltimore City

COUNTY

STATE

24. FUNERAL DIRECTOR

NAME

ADDRESS

Ambrose Funeral Home 1328 Sulphur Spring Rd.

25a. DATE REC'D. BY REGISTRAR

APR 27 1982

James J. Smith

V 7 0 8 U . 8

W 7 0 8 U . 8

M 7 0 8 U . 8

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Handwritten signature or initials at the bottom left.

Handwritten text at the bottom center, possibly a date or reference number.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 50M 1/81  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 8 2 0 8 6 5 0  |  |
|---|--|--|--|--|--|
| 1- FOR STATE REGISTRAR  |  |  |  | CERTIFICATE OF DEATH   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  |  | 2a. DATE OF DEATH  |  |
| FIRST MIDDLE LAST<br><b>CHARLOTTE L HART</b>  |  |  |  | MONTH DAY YEAR<br><b>4/20/82</b>   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |  | 2b. HOUR<br><b>3:43 P</b>  |  |
| 5. DATE OF BIRTH<br><b>October 16, 1920</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>61</b>   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 74 HRS<br>HOURS MIN.                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br><b>Virginia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE</b>                             |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>6701 N CHARLES ST GBMC</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b> |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. STREET ADDRESS<br><b>37 Othoridge Road</b>                                      |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Edgar Lafayette Long</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Omega Revis</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>    |  |
| 16b. SOCIAL SECURITY NO.<br><b>218-18-9216</b>  |  | 17. INFORMANT<br><b>Mr. John Bentley Hart</b>  |  | ADDRESS<br><b>37 Othoridge Road</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>INTRA CEREBRAL HEMORRHAGE</b><br>4310 } DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>HYPERTENSION</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 DAYS</b><br>YEARS |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>APRIL 17 19 82</b> , to <b>APRIL 20 19 82</b> , that (I) (we) lost<br>saw the deceased alive on <b>APRIL 20 19 82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |
| 22b. SIGNATURE<br><i>Barbara A. Conley MD</i>   |  |  |  | 22c. DATE SIGNED<br><b>4/20/82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BARBARA CONLEY MD</b>   |  |  |  | 22e. ADDRESS<br><b>GBMC</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>  |  | 23b. DATE<br><b>4-21-1982</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park</b>                             |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>   |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Ruck Towson Funeral Home, Inc. Towson, Maryland</b>   |  |  |  |
| 25a. DATE REC'D. BY REGISTRAR<br><b>APR 23 1982</b>   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Frances Jan Nathan</i>                              |  |

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |  |  | REG. NO. 8 2 0 8 6 5 1                                |  |                            |  |
|---|--|---|--|---|--|---|--|--|--|---|--|----------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ROSE</b> <b>HASTRY</b>   |  |   |  |   |  |   |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4 27 82</b> |  | 2b. HOUR<br><b>0715 AM</b> |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>Cauc.</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4/23/96</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS MONTHS DAYS<br><b>86</b>                                 |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |   |  |                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Balto.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. County</b> MD.                                |  |  |  |   |  |                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Balto. Co. Gen. Hosp.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>-</b>  |  |   |  |                            |  |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>Balto.</b>  |  | 13c. CITY OR TOWN<br><b>Balto.</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>511 N. Bouldin St., 21205</b>  |  |   |  |                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Cook</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Barbara Baronschmidt</b>  |  |   |  |  |  |   |  |                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>-</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Jean Eiler, 504 N. Castle Dr. 21212</b>  |  |   |  |  |  |   |  |                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br><b>4360</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>CONGESTIVE HEART FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>CEREBROVASCULAR ACCIDENT</b> |  |   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH          |  |                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>GASTRO INTESTINAL BLEEDING</b>   |  |   |  |   |  |   |  |  |  |   |  |                            |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |                            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |   |  |                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |   |  |                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |   |  |  |  |   |  |                            |  |
| 22b. SIGNATURE<br><b>Hafeez A Syed</b>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |   |  | 22c. DATE SIGNED<br><b>4/24/82</b>   |  |   |  |                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>HAFAEZ A SYED</b>   |  |   |  | 22e. ADDRESS<br><b>BALTIMORE COUNTY GEN HOSP.</b>   |  |   |  |  |  |   |  |                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(CHECK)<br><b>Burial</b>   |  | 23b. DATE<br><b>4/30/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto., Md.</b>                                |  |  |  |   |  |                            |  |
| 24. FUNERAL DIRECTOR<br><b>Schimunek Funeral Home, Inc.</b><br><b>3331 Brehms Lane, Balto., Md.</b>   |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 28 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>James J. Smith</b>  |  |   |  |                            |  |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                  |  |   |  |   |  |   |                  | REG. NO. 08652  |  |
|---|--|------------------|--|---|--|---|--|---|------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>William J Haupt, Jr</b>  |  |                  |  |   |  | 2b. DATE KNOWN OF DEATH<br>ESTIMATED <input type="checkbox"/> MONTH DAY YEAR 19 <b>APRIL 8 1982</b> |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR 19 <b>APRIL 8 1982</b>   |                  | 2d. HOUR M <b>15</b>  |  |
| 3. SEX <b>M</b>   |  | 4. RACE <b>W</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>July 22, 1899</b>                               |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY) <b>82 YRS.</b>   |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  |                  | IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>   |  |                  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALT CO</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALT</b>  |  |                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br><b>2811 Hillcrest Ave</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOUR MOST OF WORKING LIFE) <b>RETIRED</b>  |                  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Balt G &amp; E</b>                                      |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |                  |  |   |  |   |  |   |                  |   |  |
| 13a. STATE <b>MD</b>  |  |                  |  | 13b. COUNTY <b>BALT</b>   |  |   |  | 13c. STREET ADDRESS <b>2811 HILLCREST AVE</b>   |                  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST <b>William</b> MIDDLE <b>J</b> LAST <b>HAUPT Sr</b>  |  |                  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>SIGWORA</b> MIDDLE <b>P</b> LAST <b>HAUPT</b>                  |  |   |                  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>YES</b>  |  |                  |  | 16b. SOCIAL SECURITY NO.<br><b>212-05-5513</b>  |  |   |  | 17. INFORMANT<br><b>MARY DIAMOLA</b><br><b>SAM E</b>  |                  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ARTERIO SCLEROTIC CARDIOVASCULAR</b><br><b>4292</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF <b>DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF _____<br>DUE TO, OR AS A CONSEQUENCE OF _____  |  |                  |  |   |  |   |  |   |                  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |                  |  |   |  |   |  |   |                  |   |  |
| 19a. DATE OF OPERATION  |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                     |  |   |  |   |                  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                        |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                            |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |                  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                           |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                  |  |   |  |   |  |   |                  |   |  |
| ACTUAL SIGNATURE <b>Paul R Guerin</b>   |  |                  |  |   |  | TITLE (SPECIFY)<br><b>DEPUTY</b>  |  |   | MEDICAL EXAMINER |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT) <b>PAUL R GUERIN</b>   |  |                  |  |   |  | ADDRESS <b>1344 WESTERN ROW RD<br/>COCKEYSVILLE MD 21030</b>  |  |   |                  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>  |  |                  |  | 23b. DATE<br><b>4/12/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley</b>   |  |   |                  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>                        |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Leonard J Ruck Inc. Baltimore, Maryland</b>   |  |                  |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>APR 12 1982</b>  |  |   |                  |   |  |
|   |  |                  |  |   |  | 25b. REGISTRAR'S SIGNATURE <b>Shane J. [Signature]</b>  |  |   |                  |   |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

1 - FOR  
STATE  
REGISTRAR

|   |   |   |   |  |
|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>CHRISTINE L. HEALY</b>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4-27-82</b><br><b>4 27 82</b><br>10:36 am                             |  |
| 3. SEX<br><b>F</b>  | 4. RACE<br><b>W</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11-23-1916</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>65</b> YRS.<br>IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.<br>IF UNDER 24 HRS. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>         | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST. JOSEPH HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(LIST WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>                               | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>At Home</b>                                  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Md</b> 13b. COUNTY <b>BALTO</b>  |   | 13c. CITY OR TOWN<br><b>BALTO</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                 | 13e. STREET ADDRESS<br><b>2713 Chesley Ave</b>                                       |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>HENRY Longo</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ROSARIA D'Angelo</b>  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NAME OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>212-10-8493</b>  | 17. INFORMANT ADDRESS<br><b>Family Records</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARCINOMA OF THE PANCREAS</b><br><b>1579</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (c)  |   |   |   |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |
| 22a. I certify that (1) this hospital attended the deceased from <b>4/14</b> , 19 <b>82</b> , to <b>4/27</b> , 19 <b>82</b> , that (1) <b>HE</b> last saw the deceased alive on <b>4/26</b> , 19 <b>82</b> , and that in (my) <b>my</b> opinion death occurred on the date and hour and from the causes stated above, (1) <b>HE</b> (did) <b>not</b> view the body after death. |   |   |   |  |
| 22b. SIGNATURE<br><b>Charles B. Hutton</b>  |   | DEGREE<br><b>M.D.</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>4/27/82</b>   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CHARLES B. HUTTON</b>   |   | 22e. ADDRESS<br><b>7600 OSLER DR TOWSON, MD 21204</b>   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  | 23b. DATE<br><b>5-1-82</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>PARKWOOD</b>   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO Co Md</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>EVANS FUNERAL Chapel 8800 Hartford Rd</b>  |   | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>MAY 5 1982</b> <b>James Van Marthens</b>   |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 6 5 4

REG. NO.

|  |  |  |  |   |  |  |  |  |                  |
|--|--|--|--|---|--|--|--|--|------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Mathilde Marie Hebb</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 16, 1982</b>           |   | 2b. HOUR<br>A. M.<br><b>7:00 A.</b>  |  |  |  |                  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Nov. 16, 1911</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS.<br><b>70</b>                                 |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |                  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Balto., Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County, MD.</b>                 |  |  |                  |
| 10. CITY OR TOWN OF DEATH<br><b>Butler</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>2526 Butler Road - 21023</b> |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Manager</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Farm</b>   |  |                  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Butler</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>2526 Butler Road - 21023</b>   |                  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Walter C. Mylander</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Matilda Augusta Hopf</b>  |  |  |  |  |                  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br><b>213-48-3161</b>   |  | 17. INFORMANT ADDRESS<br><b>Dr. Donald B. Hebb - 2526 Butler Road-21023</b>   |  |  |  |  |                  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1: DEATH WAS CAUSED BY:<br><b>1579 IMMEDIATE CAUSE (a) Carcinoma of pancreas with metastases</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>9 mos.</b> |  |  |  |   |  |  |  |  |                  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |  |  |  |   |  |  |  |  |                  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY BY ITEM 18, PART 1 OR PART 2)     |  |  |  |                  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                  |  |  |  |                  |
| 22. I certify that (1) this hospital attended the deceased from <b>4/10</b> 19 <b>82</b> to <b>4/16</b> 19 <b>82</b> , that (1) (we) last saw the deceased alive on <b>4/10</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (I) (did) (not) view the body after death.  |  |  |  |   |  |  |  |  |                  |
| 23a. SIGNATURE<br><b>Charles J. Blazek, M.D.</b>   |  |  |  |   | DEGREE<br><b>M.D.</b>  |  | 23b. ATTENDING MEDICAL STAFF<br>PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> |  | 23c. DATE SIGNED |
| 24. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Charles J. Blazek, M.D.</b>   |  |  |  |   | 24b. ADDRESS<br><b>1116 St. Paul Street, Balto., Md.-21202</b>                     |  |  |  |                  |
| 25a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>   |  | 25b. DATE<br><b>Apr. 17, 1982</b>  |  | 25c. NAME OF CEMETERY OR CREMATORY<br><b>Green Mount Crematorium Baltimore, Md. - 21202</b>   |  | 25d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |  |                  |
| 26. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Henry Sander &amp; Sons, Inc., Balto., Md. 21213</b>  |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE<br><b>APR 19 1982</b>   |  |                  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

\_\_\_\_\_



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 6 5 5

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |   |   |   |  |  |
|---|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Henry Vincent Hedeman</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 14, 1982</b>                          |  | 2b. HOUR<br>M<br><b></b>   |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Sept 28, 1903<sup>R</sup></b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b>                                   | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b></b>  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.            |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1303 Colbury Rd</b> |   | 12a. USUAL OCCUPATION<br>(TYPE WORK OR MAIN WORKING PLACE)<br><b>Retired Salesman</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Leonard Paper</b>  |
| 13a. STATE<br><b>Maryland</b>   |   |   | 13b. COUNTY<br><b>Baltimore</b>   | 13c. CITY OR TOWN<br><b>Towson</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Alexander Hedeman</b>  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE<br><b>Margaretha Busheimer</b>               |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |   | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br><b>216-05-2256</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Mrs Thelma C Hedeman Same</b>                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u><br><b>4100</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Atherosclerotic Heart Disease</u><br>(c) <u>Hypertension</u>                |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>many yrs</u><br><u>many yrs</u>   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b></b>  |   |   |   |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>NH. 7</u> , 19 <u>77</u> , to <u>Jan. 15</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>Jan. 15</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |   |   |  |  |
| 22b. SIGNATURE<br><b>Esperanza B. Samson-Coxvera</b>  |   |   |   | 22c. DATE SIGNED<br><b>4-15-82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ESPERANZA B. SAMSON-COXVERA</b>   |   |   |   | 22e. ADDRESS<br><b>5807 Huxford Rd. BALTO. 21214</b>                           |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |   | 23b. DATE<br><b>4/17/82</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore</b>                         |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>  |   | 23e. DATE REC'D. BY REGISTRAR<br><b>APR 16 1982</b>   |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Leonard J Ruck Inc. Baltimore, Maryland</b>  |   |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>James J. Nathan</b>                           |  |

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RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE  
WASHINGTON, D. C. 20535

DATE: 4/2/68

TO: SAC, NEW YORK

FROM: SAC, NEW YORK

SUBJECT: [illegible]

RE: [illegible]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |  |  | REG. NO.  |  |                              |  |
|--|--|---|--|---|--|--|--|--|--|---|--|------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>LEO T. HELMCAMP</b>  |  |   |  |   |  |  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>04 25 82</b>         |  | 2b. HOUR<br><b>1050 A.M.</b> |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>01 03 06</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>76 YRS.</b>  |  | IF UNDER 1 YEAR MONTHS DAYS<br><b>76 YRS.</b>  |  | IF UNDER 24 HRS. HOURS MIN.<br><b>76 YRS.</b>               |  |                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>GEORGIA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY MD.</b>                          |  |  |  |   |  |                              |  |
| 10. CITY OR TOWN OF DEATH<br><b>ARBUTUS</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1316 ELM ROAD, 21227</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SIGN PAINTER</b>         |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>DEPT. OF ARMY</b>  |  |   |  |                              |  |
| 13a. STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>BALTIMORE</b>   |  | 13c. CITY OR TOWN<br><b>ARBUTUS</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>1316 ELM ROAD, 21227</b>   |  |   |  |                              |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>THOMAS J. HELMCAMP</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>MAY D. KLINE</b>   |  |  |  |  |  |   |  |                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO<br><b>216-01-4474</b>   |  | 17. INFORMANT ADDRESS<br><b>HILDA M. HELMCAMP 1316 ELM ROAD, 21227</b>  |  |  |  |  |  |   |  |                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Recurrent cerebrovascular accident</b><br><b>4029</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Hypertensive CVD</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>yes.</b> |  |   |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>yes.</b> |  |                              |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |   |  |   |  |  |  |  |  |   |  |                              |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>                    |  |   |  |                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |   |  |                              |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |   |  |                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4/24 7/30</b> , 19 <b>76</b> to <b>4/25</b> , 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>4/24</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |  |  |   |  |                              |  |
| 22b. SIGNATURE<br><b>Herbert J. Levickas M.D.</b>  |  |   |  | DEGREE<br><b>M.D.</b>   |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>4/26/82</b>                          |  |                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>HERBERT J. LEVICKAS, M.D.</b>  |  |   |  | 22e. ADDRESS<br><b>5404 EAST DRIVE; ARBUTUS, MD. 21227</b>  |  |  |  |  |  |   |  |                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>04-28-82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MEADOWRIDGE MEM. PK.</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>ELKRIDGE HOWARD MARYLAND</b>                   |  |  |  |   |  |                              |  |
| 24. FUNERAL DIRECTOR NAME<br><b>HUBBARD FUNERAL HOME, INC.</b>   |  |   |  | ADDRESS<br><b>4107 WILKENS AVE.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 28 1982</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles J. VanNathan</b>  |  |   |  |                              |  |

22

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 6 5 7

REG. NO.

FOR  
1 - STATE  
REGISTRAR

|   |  |  |  |   |   |  |
|---|--|--|--|---|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Claude L. Henry</i>                                       |  |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><i>4-24-82</i> |   | 2b HOUR<br><i>6:45 AM</i>                                       |  |
| 3 SEX<br><i>MALE</i>  | 4 RACE<br><i>WHITE</i>   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><i>10-7-96</i>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><i>85</i>   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>MARYLAND</i>   | 7b CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><i>BALTIMORE Co.</i> MD                                  |   |  |
| 10 CITY OR TOWN OF DEATH<br><i>ESSEX</i>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>RIVERVIEW NURSING CENTRE</i> |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>LABORER</i>               |   |  |
| 12b KIND OF BUSINESS OR INDUSTRY<br><i>ORCHARD</i>  |  |  |  |   |   |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><i>MD.</i> |  | 13b. COUNTY<br><i>BALTIMORE</i>  | 13c. CITY OR TOWN<br><i>ESSEX</i>                    | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><i>1 EASTERN BLVD.</i>                   |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>THOMAS I. HENRY</i>   |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>ANNA MARY BARBON</i>  |  |   |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES/NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><i>No</i>             |  | 16b SOCIAL SECURITY NO.<br><i>190-12-0964</i>  |  | 17 INFORMANT<br>ADDRESS<br><i>ANNA M. KRICK, BALTIMORE, MD.</i>                                 |   |  |

|   |  |  |
|---|--|--|
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Arteriosclerotic Coronary Vascular Disease</i><br><i>4140</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

*Bengin Pleural Effusion*

|   |  |   |  |  |   |
|---|--|---|--|--|---|
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |   |
| 22b SIGNATURE<br><i>Richard Stewart MD</i>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)  |  |   |  | 22c DATE SIGNED<br><i>4-25-82</i>  |   |
| 22e ADDRESS   |  |   |  |  |   |

|   |                                  |  |   |
|---|----------------------------------|--|---|
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>                               | 23b DATE<br><i>Apr. 27, 1982</i> | 23c NAME OF CEMETERY OR CREMATORY<br><i>Tabernacle</i> | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Whiteford Harford Maryland</i>                  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><i>John H. Harkins, 600 Main St., Delta, PA</i> |                                  |  | 25a DATE REC'D. BY REGISTRAR 25b REGISTRAR'S SIGNATURE<br><i>APR 30 1982 Frances Van Natten</i> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

12080

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 8 2 0 8 6 5 8   |  |   |   |
|---|--|---|--|---|--|---|---|
| 1 - STATE REGISTRAR   |  |   |  | REG. NO.  |  |   |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |   |  | 2a. DATE OF DEATH   |  | 2b. HOUR  |   |
| Kenneth E. Herb   |  |   |  | April 23, 1982  |  | M   |   |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE  |   |
| Male  |  | Caucasian   |  | July 14 1923  |  | 58 YRS.   |   |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |   |
| Penna.  |  | U.S.A.  |  |   |  | Baltimore County MD.  |   |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |   |
| Baltimore   |  | 2532 Windsor Avenue   |  | Conductor   |  | Railroad  |   |
| 13a. STATE  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |   |
| Md.   |  | Balto.  |  | Baltimore   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME  |  | 13e. STREET ADDRESS   |  |   |   |
| Paul  |  | Herb  |  | 2532 Windsor Avenue   |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS   |  |   |   |
| yes   |  | WW II 192-14-6973   |  | Sarah Herb (wife) same address  |  |   |   |
| 18. CAUSE OF DEATH (Enter one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY  |  |   |  |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| 1629 IMMEDIATE CAUSE (a) <i>Small cell Carcinoma of the lung</i>  |  |   |  |   |  |   |   |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |   |  |   |   |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |   |  |   |  |   |   |
| (b) <i>Brain metastasis 2° to Carcinoma</i>   |  |   |  |   |  |   |   |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |   |  |   |   |
| (c)   |  |   |  |   |  |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |   |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |   |
|   |  |   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)  |  |   |   |
|   |  | P.M. 19   |  |   |  |   |   |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION   |  |   |   |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   |  | STREET CITY OR TOWN COUNTY STATE  |  |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>May 81</i> , 19 <i>81</i> , to <i>April 11</i> , 19 <i>82</i> , that (I) (we) lost saw the deceased <i>April 10</i> , 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |   |
| 22b. SIGNATURE  |  |   |  | DEGREE  |  | 22c. DATE SIGNED  |   |
| <i>Marvin J. Feldman</i>  |  |   |  | M.D.  |  |   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |   |  | 22e. ADDRESS  |  |   |   |
| Dr. Marvin Feldman  |  |   |  | Falls & Joppa Rd.<br>302 Greenspring Station  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION   |   |
| Burial  |  | 4/27/82   |  | Gardens of Faith  |  | Baltimore Md.   |   |
| 24. FUNERAL DIRECTOR  |  |   |  | 25a. DATE REC'D. BY REGISTRAR   |  |   |   |
| Scrimmuenk Funeral Home, Inc.<br>9705 Belair Rd., Balto. Md. 21236  |  |   |  | APR 27 1982 <i>James J. Whitham</i>   |  |   |   |

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APR 27 1985



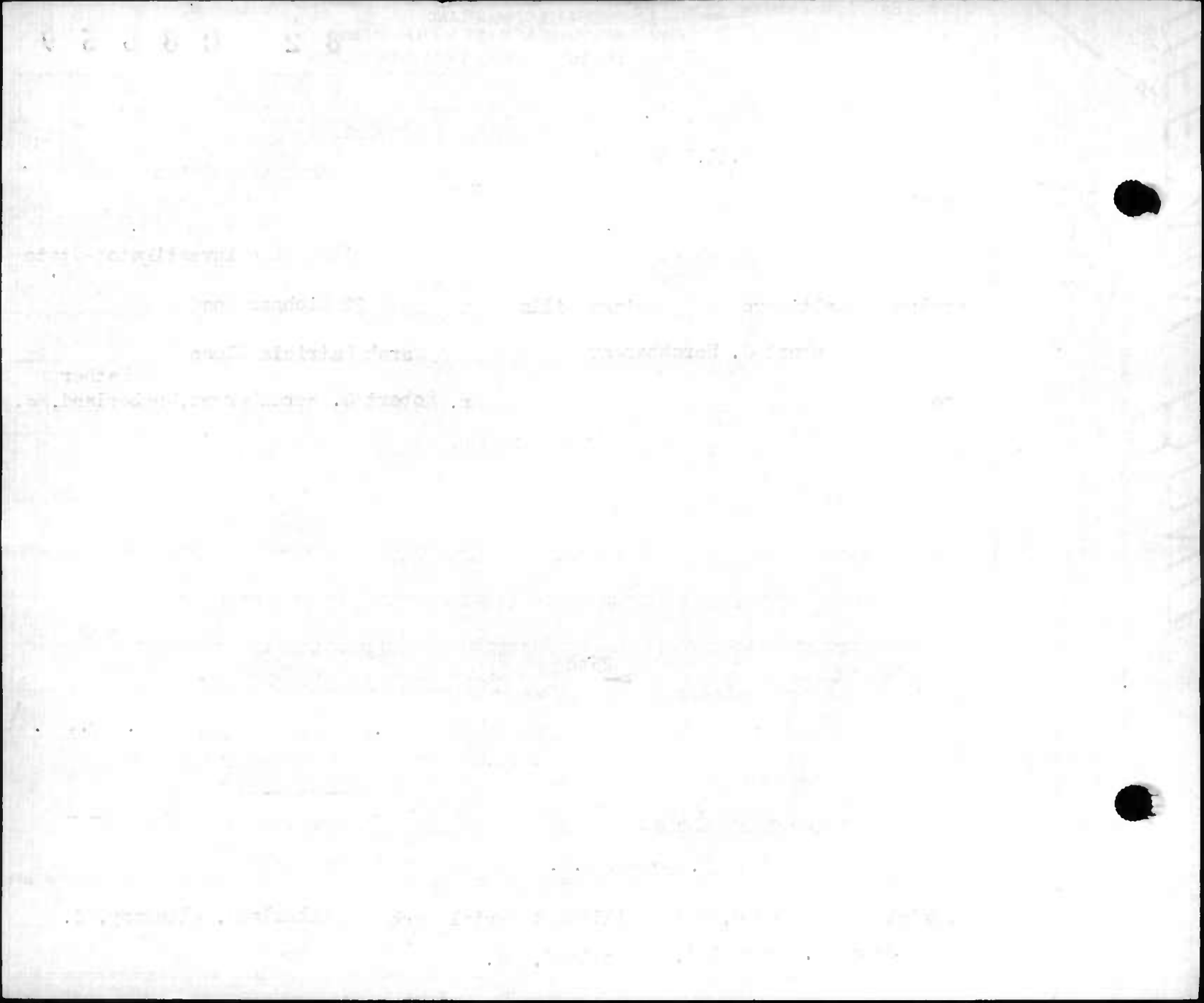
**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO. **2 0 8 6 5 9**

|  |                         |  |  |   |  |  |  |   |  |
|--|-------------------------|--|--|---|--|--|--|---|--|
| 1- FOR STATE REGISTRAR   |                         | 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST MIDDLE LAST<br><b>Willard G. Hershberger</b>  |  | 2a. DATE KNOWN OF DEATH<br>ESTI- MATED <input checked="" type="checkbox"/> <b>4 29 1982</b>      |  | 2b. HOUR<br><b>3:30 P.M.</b>  |  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Feb. 11, 1956</b>   | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br><b>26 YRS.</b> | IF UNDER 1 YR.<br>MONTHS DAYS<br><b>26</b>  | IF UNDER 24 HRS.<br>HOURS MIN<br><b>26</b> | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>4 30 1982</b>                                   |  | 2d. HOUR<br><b>3:30 P.M.</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County, Md.</b>                             |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Owings Mills</b>   |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>22 Richmar Road</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Child Abuse Investigator</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>State</b>                                   |  |
| 13a. STATE<br><b>Maryland</b>  |                         | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Owings Mills</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>22 Richmar Road</b>                                       |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Robert G. Hershberger</b>   |                         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Sarah Patricia Close</b>   |  | 16. ADDRESS<br><b>Father Mr. Robert G. Hershberger, Cumberland, Md.</b>   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>no</b>   |                         | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br><b>Mr. Robert G. Hershberger, Cumberland, Md.</b>  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>9830</b><br>IMMEDIATE CAUSE (a) <b>Asphyxia by hanging</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.   |                         |  |  |   |  |  |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |                         |  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>? P.M. 4 29 1982</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>subject found hanging in doorway</b>                                    |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>   |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>Home</b>   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>22 Richmar Rd., Owings Mills, Balto. Co., Md.</b>   |  |  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/> . |                         |  |  |   |  |  |  |   |  |
| ACTUAL SIGNATURE<br><b>Virginia L. Dolan</b>   |                         | TITLE (SPECIFY)<br><b>Assistant</b>  |  | M.D. <b>Assistant</b>   |  | MEDICAL EXAMINER   |  | DATE SIGNED<br><b>5-1-82</b>  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Virginia L. Dolan, M.D.</b>   |                         | ADDRESS<br><b>111 Penn Street</b>  |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |                         | 23b. DATE<br><b>May 4, 1982</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Hillcrest Burial Park</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Cumberland, Allegany, Md.</b>                   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>James F. Scarpelli, M.D.</b>  |                         | ADDRESS<br><b>Cumberland, Md.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 6 1982</b>  |  | 25b. REGISTRAR SIGNATURE<br><b>[Signature]</b>   |  |   |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

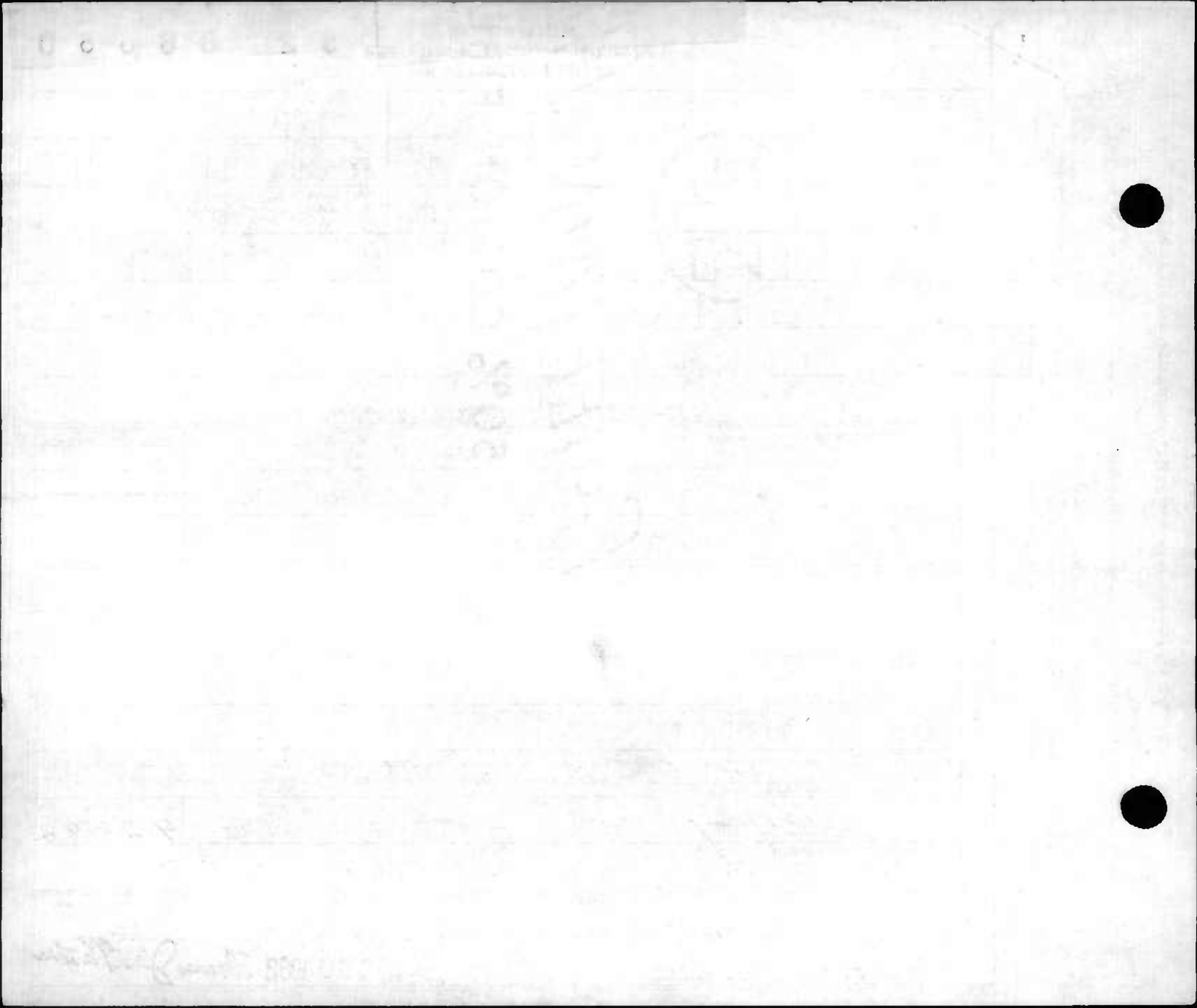


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 8 2 0 8 6 6 0   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Bessie May HEWITT</b>   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>April 28, 1982</b>   |  |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>May 28, 1892</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>89</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rosadale</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Square Hospital</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>Md.</b>  |  |   |  | 13b. COUNTY<br><b>Balto.</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>- Haynie</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Emily -</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>no</b>  |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>213-34-1358</b>  |  | 17. INFORMANT ADDRESS<br><b>Mrs. Ethel Zorbach same</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Metastatic Breast Cancer with Bone and</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Brain Metastasis</b>  |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>1749</b>  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>April 25</b> , 19 <b>82</b> , to <b>April 28</b> , 19 <b>82</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>April 28</b> , 19 <b>82</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) not view the body after death. |  |   |  |   |  |  |  |
| 22b. SIGNATURE <b>Jose Munoz, M.D.</b> DEGREE   |  |   |  |   |  | 22c. DATE SIGNED<br><b>4-28-82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Jose Munoz, M.D.</b>  |  |   |  | 22e. ADDRESS<br><b>9000 Franklin Square Dr., 21237</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>May 1, 1982</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moreland Memorial</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Leonard J. Ruck Inc. Baltimore, Md.</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 30 1982</b>   |  |  |  |
|   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Thomas J. Nathan</b>   |  |  |  |



NO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DHMH-16 50M 1/81  
(VRA 15, 4)

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |   |  |  |   |                 |   |  |
|---|--|--|---|--|--|---|-----------------|---|--|
| 1. FOR STATE REGISTRAR  |  |  |   |  |  |   |                 |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  |   |  | 2a. DATE OF DEATH  |   |                 |   |  |
| FIRST MIDDLE LAST<br>ANNA M. Hildebrand   |  |  |   |  | MONTH DAY YEAR<br>4 18 82  |   |                 |   |  |
| 3. SEX  |  | 4. RACE  |   | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |                 | 2b. HOUR  |  |
| FEMALE  |  | CAU.   |   | MONTH DAY YEAR<br>8 28 1895  |  | 86 YRS  |                 | 1 5 P.M.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |                 |   |  |
| Balto. Md.  |  | U.S.A.   |   |  |  | Balto. Co. MD.  |                 |   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                     |                 | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| Towson, Md.   |  | STELLA MARIS Hospice   |   |  |  | DRESSMAKER  |                 | -   |  |
| 13a. STATE  |  |  |   |  | 13b. COUNTY  |   |                 |   |  |
| Md.   |  |  |   |  | Balto.   |   |                 |   |  |
| 13c. CITY OR TOWN   |  |  |   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |                 |   |  |
| Towson  |  |  |   |  | DULANEY VALLEY RD.   |   |                 |   |  |
| 14. FATHER'S NAME   |  |  |   |  | 15. MOTHER'S MAIDEN NAME   |   |                 |   |  |
| FIRST MIDDLE LAST<br>PETER LORTZ  |  |  |   |  | FIRST MIDDLE LAST<br>MARGARET SCHNEIDER  |   |                 |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  |   |  | 16b. SOCIAL SECURITY NO.   |   |                 |   |  |
| No  |  |  |   |  | 216-48-1671  |   |                 |   |  |
| 17. INFORMANT   |  |  |   |  | ADDRESS  |   |                 |   |  |
| GORDON L. PELTZ,  |  |  |   |  | MD.  |   |                 |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute CVA</u><br>4279<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>ARRhythmias</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |   |  |  |   |                 |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>CONTRIBUTING TO DEATH</u>   |  |  |   |  |  |   |                 |   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19          |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |                 |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                 |                 |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8-3</u> 19 <u>73</u> , to <u>4-18</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>4-16</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.     |  |  |   |  |  |   |                 |   |  |
| 22b. SIGNATURE  |  |  |   |  | 22c. DATE SIGNED   |   |                 |   |  |
| EDDIE NAKHODA   |  |  |   |  | 4-18-82  |   |                 |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |   |  | 22e. ADDRESS   |   |                 |   |  |
| EDDIE NAKHODA   |  |  |   |  | STELLA MARIS HOSPICE-VALLEY RD   |   |                 |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION   |   |  |
| Burial  |  |  | 4/21/82   |  | Druid Ridge  |   | Pikesville, MD. |   |  |
| 24. FUNERAL DIRECTOR NAME   |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR  |   |                 |   |  |
| Henry W. Jenkins & Sons Co.<br>4905 York Road Balto., Md. 21212   |  |  |   |  | APR 19 1982  |   |                 |   |  |

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25b. REGISTRAR SIGNATURE  
Frances Jan Nathan

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1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified before burial.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |  |  | 8 2 0 8 6 6 2                                   |  |
|--|--|---|--|---|--|--|--|--|--|---|--|
| 1 - FOR<br>STATE<br>REGISTRAR  |  | REG. NO.  |  |   |  |  |  |  |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST<br>John   |  | MIDDLE<br>G   |  | LAST<br>HINES  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>April 13, 1982  |  | 2b. HOUR<br>2:45pm                              |  |
| 3 SEX<br>Male  |  | 4 RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>April 2 1889  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>93 YRS   |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS<br>HOURS MIN.                   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN<br>COUNTRY)<br>Md.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                          |  |  |  |   |  |
| 10 CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Franklin Square Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Gas Station Opr. |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>-  |  |   |  |
| 13a. STATE<br>Md.  |  | 13b. COUNTY<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br>1742 Lancaster St.  |  |  |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Peter Hines  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Marie Antonie  |  |  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>218-22-5414  |  | 17 INFORMANT<br>ADDRESS<br>Clayborne Hines (son) same address   |  |  |  |  |  |   |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest, Aspiration</u><br>4148<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Pneumonia</u><br>(c) <u>Congestive Heart Failure</u><br>DUE TO, OR AS A CONSEQUENCE OF   |  |   |  |   |  |  |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Old Anteroseptal Myocardial Infarction</u>   |  |   |  |   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>              |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>April 6</u> 19 <u>82</u> to <u>April 13</u> 19 <u>82</u> , that <input checked="" type="checkbox"/> (we) lost<br>saw the deceased alive on <u>April 13</u> 19 <u>82</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated<br>above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><u>Steven Snyder M.D.</u>  |  |   |  |   |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><u>7/13/82</u>              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Steven Snyder, M.D.   |  |   |  |   |  | 22e. ADDRESS<br>9000 Franklin Square Dr. Balto., MD 21237                            |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>4/16/82  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>1st United Evangel. Church Cem.-Balto., Md.   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto., Md.                            |  |  |  |   |  |
| 24. FUNERAL HOME<br>Schmuneck Funeral Home, Inc.<br>3331 Brehms Lane, Balto., Md. 21213  |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>APR 16 1982   |  | 25b. REGISTRAR'S SIGNATURE<br><u>James J. Nathan</u>   |  |   |  |

0800

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 2 0 8 6 6 3  
CERTIFICATE OF DEATH

|   |  |   |  |
|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  | REG. NO.  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>Benjamin MACKALL M. Hingeley  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>April 30, 1982  |  |
| 3. SEX<br>Male  | 4. RACE<br>White                       | 2b. HOUR<br>6:10/A M  |  |
| 5. DATE OF BIRTH MONTH DAY YEAR<br>June 10, 1884  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>97   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Ohio   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Electrician  |  |
| 10. CITY OR TOWN OF DEATH<br>Towson   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Construction   |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>valley view Nursing Home  |  |   |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Baltimore  |  |
| 13c. CITY OR TOWN<br>Towson   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>John Hingeley  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Anna Mackall  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>208-01-1355   |  |
| 17. INFORMANT ADDRESS<br>William B. M. Hingeley 1017 Kenilworth Drive   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Advanced Atherosclerosis</u><br>4292 DUE TO, OR AS A CONSEQUENCE OF <u>Cardiovascular disease</u><br>(b) <u>1 year</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) _____ |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  | 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1979</u> , 19 <u>82</u> to <u>4/28</u> , 19 <u>82</u> that (I) (we) last saw the deceased alive on <u>4/28</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.            |  |   |  |
| 22b. SIGNATURE<br>Gracito V. Patricio   |  | 22c. DATE SIGNED<br>4/30/82   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Gracito V. PATRICIO  |  | 22e. ADDRESS<br>2426 E. Cold Spring   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>5-3-1982   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br>Woodlawn  |  | 23d. LOCATION<br>Wilksburg, Pennsylvania  |  |
| 24. FUNERAL DIRECTOR NAME<br>Ruck Towson Funeral Home, Inc.   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 3 1982   |  |
| 25b. REGISTRAR'S SIGNATURE<br>D. Nathan   |  | 25c. REGISTRAR'S NAME<br>D. Nathan  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 6 6 4

REG. NO.

|   |  |   |   |   |  |
|---|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>CAROLYN Marie HIRSCHMANN</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>04 13 82</b>                              |   | 2b. HOUR<br><b>4:00PM</b>  |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>March 24, 1915</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b>  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE County MD.</b>                 |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>G.B.M.C. 6701 N. CHARLES STREET</b> |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Sales Clerk</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Retail Sales</b>   |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>Balto.</b>  | 13c. CITY OR TOWN<br><b>Lutherville</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br><b>19 Wendslow Rd., Lutherville, Md.</b>  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Kurrle, Sr.</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Anna Elizabeth Bickel</b>   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   | (IF YES, GIVE WAR OR DATES)<br><b>--</b>   | 16b. SOCIAL SECURITY NO.<br><b>215-10-89794</b>   | 17. INFORMANT ADDRESS<br><b>Mr. Henry C. Hirschmann, Sr. 19 Wendslow Rd.</b>        |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br><b>1629</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>SQUAMOUS CELL CANCER OF THE LUNG</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)  |  |   |   |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>04-13-82</b> to <b>04-12-82</b> , that (I) (we) lost saw the deceased <b>04-13-82</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not see the body after death)   |  |   |   |   |  |
| 22b. SIGNATURE<br><i>Blair P. Grubb</i>   |  | DEGREE  |   | 22c. DATE SIGNED<br><b>04-13-82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. BLAIR P. GRUBB</b>  |  | 22e. ADDRESS<br><b>GREATER BALTIMORE MEDICAL CENTER</b>   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  | 23b. DATE<br><b>4/16/82</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley Cem.</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Cockeysville, Maryland</b>                     |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Lemmon-Mitchell-Wiedefeld, 10 W. Padonia</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 15 1982</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><i>James Van Natten</i>   |  |

CAROLYN M. HIRSCHMANN 04 13 82 4:00PM

BALTIMORE

TOWSON 6701 N. CHARLES STREET G.B.M.C.

CARDIAC ARREST  
SQUAMOUS CELL CANCER OF THE LUNG

04-13-82 04-13-82 04-13-82

04-13-82

DR. BLAIR P. GRUBB  
GREATER BALTIMORE MEDICAL CENTER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 6 6 5

REG. NO.

|   |  |   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Aileen M. Hiser</b>                     |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 14, 1982</b>               |   |  | 2b. HOUR<br>M<br><b></b>  |  |   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Oct. 11, 1924</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>57</b>  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b></b>                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>North Carolina</b>                |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                             |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1107 Litchfield Road</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Bookkeeper</b>           |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Riggs Distler</b> |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>1107 Litchfield Road</b>        |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Adam Taylor</b>                      |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Bessie Christopher</b> |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b> |  | 16b. SOCIAL SECURITY NO.<br><b>220-18-9099</b>  |  | 17. INFORMANT ADDRESS<br><b>Carroll A. Hiser 1107 Litchfield Road</b>   |  |   |  |   |  |

|  |  |  |  |
|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma of the Cervix</b><br><b>1809</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b></b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>37 mo</b> |  |
|--|--|--|--|

|  |  |  |  |
|--|--|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |
| 19a. DATE OF OPERATION<br><b>4/11</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b></b>  |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>   |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)<br><b></b>  |  | 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                  |  |
| 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b></b>  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b></b>   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Feb</b> 19 <b>82</b> , to <b>April</b> 19 <b>82</b> , that (I) (we) lost<br>saw the deceased alive on <b>4/11</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |
| 22b. SIGNATURE<br><b>Arthur Serpick</b>  |  | DEGREE<br><b>MD</b>  |  |
| 22c. DATE SIGNED<br><b>4/15/82</b>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Arthur Serpick, M.D.</b>   |  | 22e. ADDRESS<br><b>302 Greenspring Station Baltimore, Md.</b>  |  |

|  |  |                                   |  |   |  |   |  |
|--|--|-----------------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                            |  | 23b. DATE<br><b>Apr. 17, 1982</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Leonard J. Ruck, Inc. Baltimore, Maryland</b> |  |                                   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 16 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>James J. Nathan</b>                    |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 8 2 0 8 6 6 6   |  |
|--|--|--|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | CERTIFICATE OF DEATH   |  |   |  |
| 1. DECEASED NAME   |  |  |  | 2a. DATE OF DEATH   |  |
| FIRST MIDDLE LAST<br>EDNA Pauline HITCHCOCK  |  |  |  | MONTH DAY YEAR HOUR<br>4 14 1982 10:30 P                            |  |
| 3. SEX<br>FEMALE   |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH  |  |
|  |  |  |  | MONTH DAY YEAR<br>July 10, 1903                                     |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)  |  | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 8. AGE (IN YEARS LAST BIRTHDAY)                                     |  |
| 78   |  | Maryland   |  | 78  |  |
| IF UNDER 1 YEAR  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  | IF UNDER 24 HRS   |  |
| MONTHS DAYS HOURS MIN.   |  | BALTIMORE COUNTY MD.   |  |   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION  |  | 12a. USUAL OCCUPATION   |  |
| TOWSON   |  | GBMC-6701 N. CHARLES ST.   |  | (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Home Maker               |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  |
| Maryland   |  | Baltimore  |  | Pikesville  |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  | 16. SOCIAL SECURITY NO.   |  |
| FIRST MIDDLE LAST<br>Maximillian Matzdorf  |  | FIRST MIDDLE LAST<br><del>Matilda</del> Matilda Berger   |  | 216-01-0286   |  |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES?   |  | 17b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  |
| (YES, NO OR UNKNOWN) No  |  | (IF YES, GIVE WAR OR DATES)  |  | ADDRESS Baldwin, Md<br>Mr Karl Matzdorf 4603 Langshire Rd           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |   |  |
| PART 1. DEATH WAS CAUSED BY:   |  |  |  |   |  |
| IMMEDIATE CAUSE (a) RESPIRATORY FAILURE  |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |  |
| (b) ANOXIA   |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |  |
| (c) CARDIAC ARRHYTHMIA   |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?   |  |
|  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>  |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED  |  |
| OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  | HOUR A.M. MONTH DAY YEAR   |  | (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)               |  |
| (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | P.M. 19  |  |   |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY   |  | 21f. LOCATION   |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>  |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | STREET CITY OR TOWN COUNTY STATE                                    |  |
| AT WORK <input type="checkbox"/>   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-11, 19 82, to 4-14, 19 82, that (I) (we) last saw the deceased alive on 4-14, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |
| 22b. SIGNATURE   |  | DEGREE   |  | 22c. DATE SIGNED  |  |
| GARY R. GAFFNEY MD   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 4-14-82   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |   |  |
| GARY R. GAFFNEY, M.D.  |  | GBMC-6701 N. CHARLES ST.   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY                                  |  |
| (SPECIFY)  |  | 4/17/82  |  | Druid Ridge   |  |
| Burial   |  |  |  | 23d. LOCATION   |  |
|  |  |  |  | CITY OR TOWN COUNTY STATE   |  |
|  |  |  |  | Baltimore, Maryland   |  |
| 24. FUNERAL DIRECTOR   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |
| NAME ADDRESS   |  | APR 16 1982  |  | Francis J. Nathan   |  |
| Leonard J Ruck Inc. Baltimore, Maryland  |  |  |  |   |  |

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Items 18c. Film #G566  
 1. FOR STATE REGISTRAR 4-27-82 AL  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH  
 8 2 0 8 6 6 7  
 REG. NO.

|   |  |   |   |  |                                |  |
|---|--|---|---|--|--------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Jennie M. Hoover  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>04 10 82 |  | 2b. HOUR<br>6:50 <sup>PM</sup> |  |
| 3 SEX<br>Female   |  | 4 RACE<br>Caucasian   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>05 08 97   |                                |  |
| 6 AGE (IN YEARS LAST BIRTHDAY)<br>84 YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>HOURS MIN.   |   | 8. IF UNDER 24 HRS.<br>HOURS MIN.  |                                |  |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pennsylvania  |  | 10. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   | 11. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                |  |
| 12. CITY OR TOWN OF DEATH<br>Catonsville  |  | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>House in the Pines - Catonsville |   | 14. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore Co. MD.   |                                |  |
| 15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>15a. STATE<br>Delaware |  | 15b. COUNTY<br>Wilmington   |   | 15c. CITY OR TOWN<br>Wilmington  |                                |  |
| 16. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                   |  | 16a. STREET ADDRESS<br>3431 Old Capital Trail   |   | 16b. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker  |                                |  |
| 17. KIND OF BUSINESS OR INDUSTRY  |  | 17a. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Joseph Scott   |   | 17b. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Rose Marie Baronaska   |                                |  |
| 18a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 18b. SOCIAL SECURITY NO.<br>221-26-5597   |   | 19. INFORMANT<br>Carolyn L Julian<br>126 S. Clifton Ave.<br>Wilmington, Del. 19805   |                                |  |

11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
 PART 1. DEATH WAS CAUSED BY:

4292 IMMEDIATE CAUSE (a) ACUTE RESPIRATORY FAILURE  
 DUE TO, OR AS A CONSEQUENCE OF  
 (b) ASPIRATION PNEUMONIA  
 DUE TO, OR AS A CONSEQUENCE OF  
 (c) POST-OPERATIVE PNEUMONITIS

APPROXIMATE INTERVAL  
 BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

MEDICAL CERTIFICATION

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/8</u> 19 <u>82</u> , to <u>4/10</u> 19 <u>82</u> , that (I) (we) lost<br>saw the deceased alive on <u>4/9</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><u>[Signature]</u><br>DEGREE   |  |  |  | 22c. DATE SIGNED<br><u>4/10/82</u>   |  | 22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>[Signature]</u>  |  |  |  | 22f. ADDRESS<br><u>6800 SUMMIT ST. WILMINGTON, DE 19805</u>                          |  |   |  |

|   |  |                            |  |  |  |  |  |
|---|--|----------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial-Transit              |  | 23b. DATE<br>Apr. 13, 1982 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Silverbrook  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Wilmington, New Castle, Delaware |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Nitchell-Wiedefeld Home, Inc. 6500 York Rd. |  |                            |  | 25. DATE REC'D. BY REGISTRAR 26. REGISTRAR'S SIGNATURE<br>APR 14 1982 <u>[Signature]</u> |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It must be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR   |  |   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO. 8 2 0 8 6 6 8  |  |  |  |
|---|--|---|--|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Lemma M. HOPWOOD   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>April 28, 1982  |  |  |  | 2b. HOUR<br>9:10P M   |  |  |  |
| 3. SEX<br>female  |  | 4. RACE<br>white  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>2 13 11  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>71 YRS.   |  | IF UNDER 1 YEAR MONTHS DAYS   |  | IF UNDER 24 HRS. HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Ohio   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.   |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Towson   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Dulaney-Towson Nursing Home |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>homemaking   |  |  |  |
| 13a. STATE<br>Md.   |  |   |  | 13b. COUNTY<br>Balto  |  | 13c. CITY OR TOWN<br>Towson  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>9 Joppawood Ct.   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>William D Smith  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Mildred A Lansinger   |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>no   |  |   |  | 16b. SOCIAL SECURITY NO.<br>291-10-3013   |  | 17. INFORMANT ADDRESS<br>Grace Harple Balto., Md. 21236<br>4112 Loch Loman Dr.   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b><br><b>4292</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Congestive Heart Failure</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(c) <b>Atherosclerotic Cardiovascular Disease</b> |  |   |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  |  |   |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that <del>XX</del> this hospital attended the deceased from April 22, 19 82, to April 28, 19 82, that <del>XX</del> (we) lost the deceased alive on above, <del>XX</del> (we) did <del>XX</del> view the body after death, and that in <del>XX</del> (our) opinion death occurred on the date and hour and from the causes stated  |  |   |  |   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br>Robert L. Lyles   |  |   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>4-28-82   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Robert L. Lyles MD   |  |   |  |   |  | 22e. ADDRESS<br>9000 Franklin Square Dr., 21237  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |   |  | 23b. DATE<br>4-30-82  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Green Hill Cem.  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Waynesborough, Pa.                                   |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br>Lassahn F.H. 7401  |  |   |  |   |  | ADDRESS<br>Lassahn Rd  |  | DATE REC'D. BY REGISTRAR<br>MAY 6 1982  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 6 6 9

REG. NO.

|  |  |  |   |   |  |  |   |  |  |
|--|--|--|---|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Martha E. Huffman</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 14, 1982- 9:30</b>  |   |  | 2b. HOUR P.<br><b>M</b>  |   |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>July 3, 1909</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>72</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.                              |  |
| 7a. BIRTHPLACE (CITY OR TOWN)<br><b>New Kensington, Pennsylvania</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County, MD.</b>   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Catonsville</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF IN HOSPITAL, GIVE STREET ADDRESS)<br><b>5921 Charnwood Road</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>----</b>   |  |
| 13a. STATE<br><b>Md</b>  |  |  | 13b. COUNTY<br><b>Baltimore</b>   |   | 13c. CITY OR TOWN<br><b>Catonsville</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Frank Endean</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Deedy Hartman</b>   |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, UNKNOWN) <b>No</b>   |   |  |  |
| 16b. SOCIAL SECURITY NO.<br><b>212-52-2907</b>   |  |  | 17. INFORMANT<br>ADDRESS<br><b>Catonsville, Md; 21228</b><br><b>Mrs. Carol H. Rexford-414 Westshire Drive</b> |   |  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Terminal Cancer</b><br><b>1579</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) <b>Cancer Laureans</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>3 mo</b> |  |  |   |   |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>0</b>  |  |  |   |   |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>4-14-82</b><br>P.M. <b>19</b>                           |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4-14-82</b> to <b>4-14-82</b> , that (I) (we) lost <b>1</b> saw the deceased alive on <b>4-14-82</b> above, (I) (we) (did) (did not) view the body after death.  |  |  |   |   |  |  |   |  |  |
| 22b. SIGNATURE<br><b>17 Nakazawa</b>   |  |  | DEGREE<br><b>M.D.</b>   |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>17 NAKAZAWA</b>  |  |  | 22e. ADDRESS<br><b>3350 Wilkens Ave Balto Md 21229</b>  |   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>Apr. 17, 1982</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Meadowridge Memorial</b>              |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Park-Howard Cty, Md.</b>                       |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Steering Funeral Estate</b>   |  |  | ADDRESS<br><b>756 Edmondson Ave. Catonsville, Md. 21228</b>   |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 16 1982</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>James J. Smith</b>  |  |

BP

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Wilmington

to

Wilmington

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July 1, 1901

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Baltimore County

New Kensington, D.C.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 6 7 0

REG. NO.

|  |  |   |   |  |   |
|--|--|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Virginia S. Hunter</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4 27 82</b>   |  | 2b. HOUR<br><b>2:45P M</b>  |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Nov. 8, 1923</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>58</b>   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County MD.</b>                  |   |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Greater Baltimore Medical Center</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>            | 12b. KIND OF BUSINESS OR INDUSTRY  |   |
| 13a. STATE<br><b>Maryland</b>  | 13b. COUNTY<br><b>Baltimore</b>  | 13c. CITY OR TOWN<br><b>Towson</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br><b>621 Debaugh Ave. 21204</b>                                 |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Henry Smith</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Elsie Steer</b>                             |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>219-20-8676</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>Mr. Richard S. Hunter, Jr. Same as #13e</b>           |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary failure</b><br><b>4920</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Severe chronic pulmonary emphysema</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |   |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/><br>AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>April 19</b> , 19 <b>82</b> , to <b>April 27</b> , 19 <b>82</b> , that (I) (we) lost<br>saw the deceased alive on <b>April 27</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                         |  |   |   |  |   |
| 22b. SIGNATURE<br><i>R. Breiteneker</i>  |  |   |   | 22c. DATE SIGNED<br><b>4-28-82</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Rudiger Breiteneker, M.D.</b>  |  |   |   | 22e. ADDRESS<br><b>6701 N. Charles St. Towson, MD 21204</b>                          |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>4-30-82</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley Cemetery</b>                 |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Cockeysville, Maryland</b>  |  | 23e. NAME OF CEMETERY OR CREMATORY<br><b>Cockeysville, Maryland</b>   |   |  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>=Ruck Towson Funeral Home, Inc. Towson, Md. 21204</b>   |  | ADDRESS<br><b>1050 York Rd.</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 29 1982</b>                                  |   |
| 25b. REGISTRAR<br><i>Frances J. Smith</i>  |  |   |   |  |   |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |  |   |   |  |  |
|--|--|---|--|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>MARIE J. JACKINS.</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>04 11 82</b> |   | 2b. HOUR<br><b>3<sup>50</sup> P.M.</b>   |   |   |  |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>CAUCASION</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>04 30 95</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b>  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                             |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore County General Hos.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Hairdresser</b>          |   | 12b. KIND OF BUSINESS OR INDUSTRY                                |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>--</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>1010 Andover Road</b>                  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Henry Ostendorf</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Maria Agnes Fetsch</b>  |  |   |  | 16. ADDRESS<br><b>Timonium, MD</b>  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>A 218-32-4252</b>  |  | 17. INFORMANT<br><b>Mary Thomas</b> 116 Greenmeadow Drive   |  |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>RENAL FAILURE &amp; ACIDEMIA</b><br><b>5860</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |  |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>ARTERIOSCLEROTIC HEART DISEASE, RHEUMATOID ARTHRITIS</b>   |  |   |  |   |  |   |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>_____  |  |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>_____   |  | 21f. LOCATION<br>STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____   |  |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4-9-1982</b> to <b>4-11-1982</b> that (I) (we) lost saw the deceased alive on <b>4-11-1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |   |  |  |
| 22b. SIGNATURE<br><b>Sudhir Patel</b>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>4-11-82</b>  |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. SUDHIR. D. PATEL</b>   |  |   |  | 22e. ADDRESS<br><b>BAL. COUNTY GEN. HOSPITAL</b>  |  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>April 14, 1982</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral</b>  |  | 23d. LOCATION<br>CITY OR TOWN <b>Baltimore</b> COUNTY <b>Maryland</b> STATE _____               |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Loring Byers Funeral Directors</b><br><b>8728 Liberty Road Randallstown, MD 211</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>33 APR 13 1982</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles J. Whitman</b>   |   |  |  |

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FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 6 7 2

REG. NO.

|   |                        |  |  |  |                            |
|---|------------------------|--|--|--|----------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Anna Jaczynski</b> |                        |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4-9-82</b> |  | 2b. HOUR<br><b>8:20 AM</b> |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>Cauc</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 21 94</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>88</b> YRS.                                  |                            |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>                      |                        | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                |                            |
| 10. CITY OR TOWN OF DEATH   |                        | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Valley Day Care Center</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>PRESSER</b> |                            |
| 13a. STATE<br><b>MD</b>   |                        | 13b. CITY OR TOWN<br><b>BALTO</b>  |  | 13c. STREET ADDRESS<br><b>313 HORREL ST</b>  |                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ARTHUR J JACZYNSKI</b>               |                        | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MARY MICHALAK</b>  |  | 16b. SOCIAL SECURITY NO.   |                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b> |                        | 16c. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br><b>MELVIN KOWALEWSKI</b>  |                            |
| 16d. ADDRESS<br><b>BALTO MD.</b>  |                        | 16e. ADDRESS<br><b>313 HORREL ST</b>   |  | 16f. ADDRESS<br><b>313 HORREL ST</b>   |                            |

|   |  |   |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>4149 Arteriosclerotic Coronary Artery Disease</b> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b)   |  |   |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |   |

|   |  |  |   |
|---|--|--|---|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |   |
| <b>Cerebrovascular Insufficiency</b>  |  |  |   |
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |
| 22a. I certify that (I) <del>(the hospital)</del> attended the deceased from <b>4-8</b> <b>Oct.</b> 19 <b>80</b> , to <b>4-9</b> 19 <b>82</b> , that (I) <del>(we)</del> lost<br>saw the deceased alive on <b>4-8</b> 19 <b>82</b> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated<br>(I) <del>(we)</del> (did not) view the body after death. |  |  |   |
| 22b. SIGNATURE<br><b>Marion C. Kowalewski</b>   |  | DEGREE<br><b>MD</b>  | 22c. DATE SIGNED<br><b>4-12-82</b>  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MARION C. KOWALEWSKI</b>  |  | 22e. ADDRESS<br><b>8604 HARFORD RD BALTO MD 21234</b>                          |   |

|  |                             |  |   |
|--|-----------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>                        | 23b. DATE<br><b>4-13-82</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>HOLY ROSARY</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO MD</b> |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>JOHN M. WEBER &amp; SONS INC S CHSTER</b> |                             | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 14 1982</b>      | 25b. REGISTRAR<br><b>Charles J. Nathan</b>                    |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be contacted at once.

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FOR  
1 - STATE  
REGISTRAR

22a

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 6 7 3

REG. NO.

|   |   |   |   |  |  |  |  |  |
|---|---|---|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |   |   | 2a. DATE OF DEATH   |  |  | 2b. HOUR   |  |  |
| FIRST MIDDLE LAST<br>Walter L. JASINSKI   |   |   | MONTH DAY YEAR<br>April 16, 1982  |  |  | 9:30 p.m.  |  |  |
| 3. SEX<br>MALE  | 4. RACE<br>WHITE  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8 4 08  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>73 YRS.  |  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS  |  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>MD.   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                    |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>ROSEDALE   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>FRANKLIN SQUARE |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>RETIRED                     |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| 13a. STATE<br>MD.   | 13b. COUNTY<br>BALTO.   | 13c. CITY OR TOWN<br>ESSEX  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  | 13e. STREET ADDRESS<br>956 SENECA PK RD.   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>JOSEPH JASINSKI   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MARY POTIASKI                                  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR SERVICE)<br>YES WW II   |   |   | 16b. SOCIAL SECURITY NO.<br>215 14 9945   |  |  | 17. INFORMANT<br>ADDRESS<br>EDW. JASINSKI 956 SENECA PK RD.  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Sepsis<br>0389<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |   |   |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |   |   |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from April 16, 1982, to April 16, 1982, that (we) lost saw the deceased alive on April 16, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (not) view the body after death.                         |   |   |   |  |  |  |  |  |
| 22b. SIGNATURE<br>Rothbaum  |   |   |   | DEGREE   |  | 22c. DATE SIGNED<br>4-16-82  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>K. J. Rothbaum, M. D.  |   |   |   | 22e. ADDRESS<br>9000 Franklin Square Drive, 21237                                    |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SEE IF)   |   | 23b. DATE<br>4/19/82  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>ST. STANISLAUS                                 |  | 23d. LOCATION<br>CITY OR TOWN COUNTY<br>BALTIMORE  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>RAYMOND L. KACZOROWSKI  |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br>APR 20 1982   |  |  |  |  |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4, may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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W. 2. 4. 11  
Joseph Thompson  
1000 1st St. N. W.  
Washington, D. C.

APR 30 1903  
J. H. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 6 7 4  
REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTER  |  | 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Lillian A. Johnson</b>  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4-30-82</b>   |  | 2b. HOUR<br><b>8:50</b> A M  |  |
| 3. SEX<br><b>FEM.</b>  |  | 4. RACE<br><b>Can.</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 25 1890</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><b>92</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>ST. MARYS Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO Co.</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson Md.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>STELLA MARIS Hospice</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Chief OPERATOR</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Telephone Co.</b>  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>BALTO.</b>   |  | 13c. CITY OR TOWN<br><b>Towson</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James N. Johnson</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Georgina LEGRAND</b>   |  | 13e. STREET ADDRESS<br><b>Stella Maris Hospice 21<br/>Dulaney Valley Rd. Towson Md. 21214</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>212-05-0081</b>   |  | 17. INFORMANT<br><b>STELLA MARIS Hospice Towson Md. 21214</b>   |  | ADDRESS  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Longbow Heart Failure</b><br><b>4292</b> DUE TO, OR AS A CONSEQUENCE OF <b>Alcohol A.C.V.D.</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Arteriosclerosis</b> |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>OCT 19 78</b> to <b>Apr 30 19 82</b> that (I) (we) last saw the deceased alive on <b>19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Eddie Nakhuda</b>   |  | DEGREE<br><b>MD</b>  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Eddie Nakhuda MD</b>   |  | 22e. ADDRESS<br><b>STELLA MARIS Hospice</b>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>5/3/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md.</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>MITCHELL-WIEDEFELD HOME, INC. 6500 York Rd.</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 5 1982</b>  |  |  |  |

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BP

DHMH - 16 50M 1/B1  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 of 2 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |   |  |   |   |  |  | 8 2 0 8 6 7 5   |  |
|---|--|---|--|---|--|---|---|--|--|---|--|
| 1 - FOR STATE REGISTRAR   |  |   |  |   |  |   |   |  |  | REG. NO.  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>CHARLES HOWARD JONES</b>  |  |   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>APR 10 1982</b>                             |   | 2b. HOUR<br>MIN.<br><b>5 12</b>  |  | M   |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>BLACK</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>01 16 03</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YEARS MONTHS DAYS<br><b>79</b>                     |   | IF UNDER 1 YEAR<br>HOURS MIN.  |  | IF UNDER 24 HRS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N. CAROLINA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CO. MD.</b>                      |   |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>MULTI-MEDICAL N.H.</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SELF EMPLOYED</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>RETIRED</b>  |  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b>   |  |   |  | 13b. COUNTY<br><b>A.A.</b>  |  | 13c. CITY OR TOWN<br><b>SAVERNA PARK</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>210 BALTIMORE ANNAPOLIS BLVD.</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Holly Jones</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ANOROA</b>  |  |   |   |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>no</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>213-34-24334</b>   |  | 17. INFORMANT<br><b>IRMA T. BATANG</b>  |  |   |   | ADDRESS<br><b>7700 YORK RD. TOWSON MD. 21204</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO PULMONARY ARREST</b><br><b>4366</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>CARDIO VASCULAR ACCIDENT</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>a) sepsis b) decubitus ulcers c) stroke</b> |  |   |  |   |  |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |   |   |  |  |   |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                   |   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19         |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |   |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |   |  |  |   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>3</b> , 19 <b>82</b> , to <b>4</b> , 19 <b>82</b> , that (I) (do) (do not) saw the deceased alive on <b>4/7</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.  |  |   |  |   |  |   |   |  |  |   |  |
| 22b. SIGNATURE<br><b>Carl S. Friedman</b>   |  |   |  |   |  | DEGREE<br><b>MD</b>   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>4/13/82</b>                          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Carl S. Friedman</b>  |  |   |  |   |  | 22e. ADDRESS<br><b>M.D. 660 Kenilworth Dr., Towson, Md.</b>                           |   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (IF)<br><b>BURIAL</b>   |  |   | 23b. DATE<br><b>4/15/82</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Deer Run York Mt</b>                  |   | 23d. LOCATION (CITY OR TOWN COUNTY STATE)<br><b>Baltimore MD 21227</b>    |  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Marshall P. Hayes 638 N. Gilmor St</b>   |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 19 1982</b>                                   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Anna Jan Math</b>   |  |   |  |

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CHARLES HOWARD JONES  
MACE  
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Baltimore  
APR 10, 1985 2 10

algebraic polynomial where 2 stroke

Carl 2 Friedman  
Carl 1 Friedman  
APR 10 1985

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND; 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

Items #18a-22a Film G567 5/12/82 STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR

2 0 8 6 7 6

REG. NO.

|  |         |                            |   |                |                  |   |      |  |   |  |  |  |  |  |
|--|---------|----------------------------|---|----------------|------------------|---|------|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         |                            | 2a. DATE KNOWN OF DEATH                                     |                |                  | 2b. DATE ESTIMATED  |      |  | 2c. DATE PRONOUNCED DEAD  |  |  | 2d. HOUR                                     |  |  |
| FIRST MIDDLE LAST<br>William Jones   |         |                            | MONTH DAY YEAR<br>4 12 19 82                                |                |                  | MONTH DAY YEAR<br>4 12 19 82  |      |  | MONTH DAY YEAR<br>4 12 19 82  |  |  | HOUR<br>11:18 P.M.                           |  |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH           | 6. AGE (IN YEARS)   | IF UNDER 1 YR. | IF UNDER 24 HRS. |   |      |  |   |  |  |  |  |  |
| Male   | Black   | MONTH DAY YEAR<br>09 11 34 | LAST BIRTHDAY<br>47 YRS.                                    | MONTHS         | DAYS             | HOURS   | MIN. |  |   |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         |                            | 7b. CITIZEN OF WHAT COUNTRY?                                |                |                  | 8. MARRIED  |      |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |  |  |  |
| Maryland   |         |                            | USA   |                |                  | WIDOWED   |      |  | Baltimore County, MD.   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |         |                            | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION    |                |                  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                 |      |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |  |  |  |
| Baltimore  |         |                            | 23 Capella Road   |                |                  | Truck Driver  |      |  |   |  |  |  |  |  |
| 13a. STATE   |         |                            | 13b. COUNTY   |                |                  | 13c. CITY OR TOWN   |      |  | 13d. INSIDE CITY LIMITS?  |  |  | 13e. STREET ADDRESS                          |  |  |
| MD   |         |                            | Baltimore   |                |                  |   |      |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  | 8869 Fontana Lane                            |  |  |
| 14. FATHER'S NAME  |         |                            | 15. MOTHER'S MAIDEN NAME                                    |                |                  |   |      |  |   |  |  |  |  |  |
| FIRST MIDDLE LAST<br>John H Jones  |         |                            | FIRST MIDDLE LAST<br>Mildred Cook                           |                |                  |   |      |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?   |         |                            | 16b. SOCIAL SECURITY NO.                                    |                |                  | 17. INFORMANT   |      |  | ADDRESS   |  |  |  |  |  |
| NO   |         |                            | 219 306 741   |                |                  | Mildred Myers   |      |  | 8869 Fontana Lane   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:   |         |                            |   |                |                  |   |      |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |
| 4292 IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular disease   |         |                            |   |                |                  |   |      |  |   |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:  |         |                            |   |                |                  |   |      |  |   |  |  |  |  |  |
| (b)  |         |                            |   |                |                  |   |      |  |   |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |         |                            |   |                |                  |   |      |  |   |  |  |  |  |  |
| (c)  |         |                            |   |                |                  |   |      |  |   |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |         |                            |   |                |                  |   |      |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |         |                            | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |                |                  |   |      |  | 20. AUTOPSY?  |  |  |  |  |  |
|  |         |                            |   |                |                  |   |      |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         |                            | 21b. TIME OF INJURY   |                |                  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |      |  |   |  |  |  |  |  |
|  |         |                            | HOUR A.M. MONTH DAY YEAR<br>P.M. 19                         |                |                  |   |      |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |         |                            | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |                |                  | 21f. LOCATION   |      |  |   |  |  |  |  |  |
|  |         |                            |   |                |                  | STREET CITY OR TOWN COUNTY STATE  |      |  |   |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |         |                            |   |                |                  |   |      |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE   |         |                            | TITLE (SPECIFY)   |                |                  |   |      |  | DATE SIGNED   |  |  |  |  |  |
| Virginia L. Dolan  |         |                            | M.D. Assistant MEDICAL EXAMINER                             |                |                  |   |      |  | 4-13-82   |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |         |                            | ADDRESS   |                |                  |   |      |  |   |  |  |  |  |  |
| Virginia L. Dolan, M.D.  |         |                            | 111 Penn Street   |                |                  |   |      |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |         |                            | 23b. DATE   |                |                  | 23c. NAME OF CEMETERY OR CREMATORY  |      |  | 23d. LOCATION   |  |  |  |  |  |
| Burial   |         |                            | 19 Apr 82   |                |                  | Holly Hill Cemetery   |      |  | Baltimore Co. MD  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR   |         |                            | 25a. DATE REC'D. BY REGISTRAR                               |                |                  |   |      |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |  |  |
| Wm C Brown Comm F/H 1206-08 W. North Ave   |         |                            | APR 29 1982   |                |                  |   |      |  | Frances J. Smith  |  |  |  |  |  |

*[Faint, illegible handwriting throughout the page, likely bleed-through from the reverse side.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at (301) 336-3585.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |   |  | 8 2 0 8 6 7 7                                |  |
|--|--|--|--|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO.   |  |  |  |  |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST  |  | MIDDLE   |  | LAST   |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  | 2b. HOUR M                                   |  |
| Ethel MAY Jugo   |  |  |  |  |  |  |  | April 25, 1982  |  | 8:50 a                                       |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR MONTHS DAYS   |  | IF UNDER 24 HRS. HOURS MIN.                  |  |
| Female   |  | White  |  | Sept 11, 1918  |  | 63 YRS.  |  |   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |   |  |  |  |
| Maryland   |  | U.S.A.   |  |  |  | Baltimore County MD.   |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY            |  |
| Towson   |  | Saint Joseph Hospital  |  |  |  |  |  | Machine Operator  |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS   |  |  |  |
| Md.  |  | Balto Co.  |  | Timonium   |  |  |  | 112 Northwood Dr.   |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |  |  |  |  |   |  |  |  |
| Frederick W. Hall  |  | Emma Viola Garns   |  |  |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS  |  |  |  |   |  |  |  |
| NO   |  | 218 09 9751  |  | Doris Borig Same as 13 e   |  |  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> 4960   |  |  |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CO PD</u> (c) <u>ASCVD</u>   |  |  |  |  |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)                                     |  | 21i. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |  |  |
| 22a. I certify that (X) (this hospital) attended the deceased from April 4, 19 82, to April 25, 19 82, that (X) (we) lost saw the deceased alive on April 25, 19 82, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |   |  |  |  |
| 22b. SIGNATURE   |  | DEGREE   |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED  |  |  |  |
| Kamal M. Jain  |  |  |  |  |  |  |  |   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |  |  |  |  |   |  |  |  |
| Kamal M. Jain, M.D.  |  | 7620 York Rd., Towson, MD 21204  |  |  |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| Burial   |  | 4/28/82  |  | Glen Haven Mem Pk  |  | Glen Burnie A.A. Md.   |  |   |  |  |  |
| 24. FUNERAL DIRECTOR NAME  |  | 24b. ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |  |  |
| George J. Gonce  |  | 4001 Ritchie Hgwy  |  | 21225  |  | APR 27 1982  |  |   |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by note.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |   |   |  |   |  |  | 8 2 0 8 6 7 8  |  |                  |  |                     |  |
|---|--|---|--|---|---|--|---|--|--|--|--|------------------|--|---------------------|--|
| 1- FOR STATE REGISTRAR  |  |   |  |   |   |  |   |  |  | REG. NO.   |  |                  |  |                     |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>William Stewart Kain   |  |   |  |   |   |  |   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>4 30 82                 |  |                  |  | 2b. HOUR<br>1 1/4 M |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10 5 30   |   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>51 YRS.                |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                      |  | IF UNDER 24 HRS. |  |                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>US  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Balto. City Co MD |  |  |  |  |                  |  |                     |  |
| 10. CITY OR TOWN OF DEATH<br>Balto. City  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>62 Helmsman Ct. Balto. Md 21221 |  |   | 12a. USUAL OCCUPATION<br>(Home) Inspector |  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Constr.   |  |  |  |                  |  |                     |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Balto.   |  | 13c. CITY OR TOWN<br>Balto.   |   | 13d. INSIDE CITY LIMITS<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS<br>62 Helmsman Ct Balto Md 21221   |  |  |  |                  |  |                     |  |
| 14. FATHER'S NAME<br>William J. Kain  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>Julia Ritt  |   |  |   |  |  |  |  |                  |  |                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES; NO OR UNKNOWN)<br>Yes  |  | 16b. SOCIAL SECURITY NO.<br>Korean  |  | 17. INFORMANT (Son)<br>Wm. J. Kain II   |   | ADDRESS<br>62 Helmsman Ct Balto Md   |   |  |  |  |  |                  |  |                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) PNEUMONIA<br>1629<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) METASTATIC LUNG CARCINOMA<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) N/A<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1-2 WK<br>3 MO |  |                  |  |                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br>Recent Pathol Hip FX Y/A walking  |  |   |  |   |   |  |   |  |  |  |  |                  |  |                     |  |
| 19a. DATE OF OPERATION<br>4-12-82   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>HIP FX  |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>      |  |  |  |                  |  |                     |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br>N/A  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>N/A 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br>N/A   |   |  |   |  |  |  |  |                  |  |                     |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> WHILE NOT AT WORK <input type="checkbox"/><br>N/A  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>N/A  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>N/A  |   |  |   |  |  |  |  |                  |  |                     |  |
| 22a. I certify that (I) (his hospital) attended the deceased from<br>30 APR 19 82 to APR 19 82 that (I) (we) last saw the deceased alive on<br>above date (we) (did not) view the body after death.   |  |   |  |   |   |  |   |  |  |  |  |                  |  |                     |  |
| 22b. SIGNATURE<br>C. N. Schoenfeld MD   |  |   |  |   |   | DEGREE<br>MD   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>4-30-82                                    |  |                  |  |                     |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>C N SCHOENFELD   |  |   |  |   |   | 22e. ADDRESS<br>201 E UNION PKWY BALTO MD 21218  |   |  |  |  |  |                  |  |                     |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>5/3/82   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Parkwood  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland                              |   |  |  |  |  |                  |  |                     |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Leonard J Ruck Inc. Baltimore, Maryland   |  |   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>MAY 3 1982  |   | 25b. REGISTRAR'S SIGNATURE<br>Theresa Jan Thistle  |  |  |  |                  |  |                     |  |

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APR 10 1968

23 24 25 26 27 28 29 30

31 MAY 1 2 3 4 5 6 7 8 9 10

11 12 13 14 15 16 17 18 19 20

21 22 23 24 25 26 27 28 29 30

31 JUN 1 2 3 4 5 6 7 8 9 10

11 12 13 14 15 16 17 18 19 20

21 22 23 24 25 26 27 28 29 30

31 JUL 1 2 3 4 5 6 7 8 9 10

11 12 13 14 15 16 17 18 19 20

21 22 23 24 25 26 27 28 29 30

31 AUG 1 2 3 4 5 6 7 8 9 10

11 12 13 14 15 16 17 18 19 20

21 22 23 24 25 26 27 28 29 30

31 SEP 1 2 3 4 5 6 7 8 9 10

11 12 13 14 15 16 17 18 19 20

21 22 23 24 25 26 27 28 29 30

31 OCT 1 2 3 4 5 6 7 8 9 10

11 12 13 14 15 16 17 18 19 20



APR 10 1968



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/B1  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |                     |  | 8 2 0 8 6 7 9   |     |            |                    |
|---|--|---|--|---|--|---|--|---------------------|--|-----------------|-----|------------|--------------------|
| 1. FOR<br>STATE<br>REGISTRAR  |  | REG. NO.  |  |   |  |   |  |                     |  |                 |     |            |                    |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST   |  | MIDDLE  |  | LAST  |  | 2a. DATE OF DEATH   |  | MONTH           | DAY | YEAR       | 2b. HOUR           |
| CHRIS   |  | KAMBERIS  |  |   |  |   |  | APRIL 26, 1982      |  |                 |     |            | 5:12P <sup>M</sup> |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR     |  | IF UNDER 24 HRS |     |            |                    |
| MALE  |  | White   |  | MAY 31, 1901  |  | 80 YRS  |  | MONTHS              |  | DAYS            |     | HOURS MIN. |                    |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                     |  |                 |     |            |                    |
| Greece  |  | U.S.A.  |  |   |  | BALTO. COUNTY   |  |                     |  |                 |     | MD.        |                    |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION             |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                     |  |                 |     |            |                    |
| TOWSON  |  | ST JOSEPH HOSPITAL  |  | Cook  |  | Restaurant  |  |                     |  |                 |     |            |                    |
| 13a. STATE  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS |  |                 |     |            |                    |
| Maryland  |  | Baltimore   |  | Towson  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 33 Willow Ave       |  |                 |     |            |                    |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME  |  |   |  |   |  |                     |  |                 |     |            |                    |
| FIRST MIDDLE LAST   |  | FIRST MIDDLE LAST   |  |   |  |   |  |                     |  |                 |     |            |                    |
| Athanasius  |  | Kamberis  |  | Tasia   |  |   |  |                     |  |                 |     |            |                    |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT   |  | ADDRESS   |  |                     |  |                 |     |            |                    |
| NO  |  | 093-10-0148   |  | Mrs. Sevasti Ricas  |  | 500 Virginia Ave Towson   |  | 21204               |  |                 |     |            |                    |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:   |  | CHRONIC RENAL FAILURE   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |   |  |                     |  |                 |     |            |                    |
| IMMEDIATE CAUSE (a)   |  | Chronic Renal Failure   |  |   |  |   |  |                     |  |                 |     |            |                    |
| 4409  |  | DUE TO, OR AS A CONSEQUENCE OF                                      |  | ADVANCED ARTERIOSCLEROSIS   |  |   |  |                     |  |                 |     |            |                    |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  | (b)   |  | Advance Arteriosclerosis  |  |   |  |                     |  |                 |     |            |                    |
|   |  | DUE TO, OR AS A CONSEQUENCE OF                                      |  |   |  |   |  |                     |  |                 |     |            |                    |
|   |  | (c)   |  |   |  |   |  |                     |  |                 |     |            |                    |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |   |  |                     |  |                 |     |            |                    |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |                     |  |                 |     |            |                    |
|   |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |                     |  |                 |     |            |                    |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |                     |  |                 |     |            |                    |
|   |  | HOUR A.M. MONTH DAY YEAR  |  |   |  |   |  |                     |  |                 |     |            |                    |
|   |  | P.M. 19   |  |   |  |   |  |                     |  |                 |     |            |                    |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION   |  |   |  |                     |  |                 |     |            |                    |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   |  | STREET  |  | CITY OR TOWN  |  | COUNTY              |  | STATE           |     |            |                    |
|   |  |   |  |   |  |   |  |                     |  |                 |     |            |                    |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from APRIL 17, 19 82, to APRIL 26, 19 82, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on APRIL 26, 19 82, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |                     |  |                 |     |            |                    |
| 22b. SIGNATURE  |  | DEGREE  |  | 22c. DATE SIGNED  |  |   |  |                     |  |                 |     |            |                    |
| Beatriz P. Dizon, M.D.  |  | M.D.  |  | APR 26, 1982  |  |   |  |                     |  |                 |     |            |                    |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS  |  |   |  |   |  |                     |  |                 |     |            |                    |
| BEATRIZ DIZON, M.D.   |  | 7620 YORK RD - TOWSON MD 21204                                      |  |   |  |   |  |                     |  |                 |     |            |                    |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION   |  |                     |  |                 |     |            |                    |
| Burial  |  | 4-29-82   |  | Greek Orthodox  |  | Baltimore   |  |                     |  |                 |     |            |                    |
|   |  |   |  |   |  | COUNTY  |  | STATE               |  |                 |     |            |                    |
| 24. FUNERAL DIRECTOR  |  | 25a. DATE REC'D BY REGISTRAR  |  |   |  |   |  |                     |  |                 |     |            |                    |
| NAME  |  | ADDRESS   |  | MAY 3 1982  |  |   |  |                     |  |                 |     |            |                    |
| Mitchell-Wiedefeld Home   |  | 6500 York Rd 21212  |  |   |  |   |  |                     |  |                 |     |            |                    |

MEDICAL CERTIFICATION

29

BP

08019

OFFICE OF THE ATTORNEY GENERAL

22

COURT

RECEIVED

1000 11th Ave

Telephone

Address

Topic

Subject

Reference

RECEIVED 1000 11th Ave

RECEIVED

Telephone

Address

Reference

Subject

1000 11th Ave - 1000 11th Ave

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |   |  |  | 8 2 0 8 6 8 0                     |  |
|---|--|---|--|---|--|---|---|--|--|-----------------------------------|--|
| 1. FOR STATE REGISTRAR  |  | REG. NO.  |  |   |  |   |   |  |  |                                   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Helen C. Kane</b>  |  |   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 3, 1982</b>                                     |   |  | 2b. HOUR<br>MIN.<br><b>5:45 A.</b>   |                                   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Feb. 10, 1899</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS.<br><b>83</b>  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Rushville, Ind.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County,</b> MD.                            |   |  |  |                                   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>8222 Jeffers Circle</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>            |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>----</b>   |  |                                   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE 13b. COUNTY 13c. CITY OR TOWN<br><b>Md. Baltimore Towson</b>   |  |   |  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>8222 Jeffers Circle</b>  |  |                                   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Otto E. Morris</b>   |  |   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Gertrude Mahern</b>                         |   |  |  |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>-----</b>   |  | 17. INFORMANT <b>Stevensville, Md. 21666.</b><br><b>Mrs. Mary K. Harvey-P.O. Box 333</b>  |  |   |   |  |  |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Failure</b><br><b>4292</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Cerebrovascular accident</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>ASCVD</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 mos</b><br><b>1 yr</b><br><b>5 yrs</b> |  |   |  |   |  |   |   |  |  |                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |   |   |  |  |                                   |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |   |  |  |                                   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |   |  |  |                                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/14/81</b> to <b>4/3/82</b> , that (we) last saw the deceased alive on <b>4/1/82</b> , and that (my) (our) opinion of death occurred on the date and hour and from the causes stated.   |  |   |  |   |  |   |   |  |  |                                   |  |
| 22b. SIGNATURE<br><b>George I. Gilmore MD</b>   |  |   |  |   |  | DEGREE<br><b>MD</b>   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>4/5/82</b> |  |
| 23a. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |   |  |   |  | 23b. ADDRESS  |   |  |  |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |   | 23b. DATE<br><b>Apr. 6, 1982</b>                                       |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral Cemetery - Baltimore, Md.</b> |   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |                                   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Starling Funeral Estate</b>  |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 7 1982</b>  |   |  |  |                                   |  |
| ADDRESS<br><b>736 Edmondson Ave.<br/>Catonville, Md. 21228</b>  |  |   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>James J. [Signature]</b>                                       |   |  |  |                                   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner's notes be not filed at this time.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 8 2 0 8 6 8 1  |  |   |  |
|---|--|--|--|--|--|---|--|
| 1- FOR STATE REGISTRAR  |  |  |  | REG. NO.   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Katherine KARAS</b>   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>April 30, 1982</b>  |  |   |  |
| 2b. HOUR<br><b>1:05</b> <sup>a</sup> <sub>m</sub>   |  |  |  |  |  |   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Cauc.</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Aug. 30, 1902</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS<br><b>79</b>  |  |
| 7a. BIRTHPLACE (COUNTRY) [STATE OR FOREIGN]<br><b>Baltimore, Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore, Md.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Square Hosp.</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>homemaker</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>--</b>  |  |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>--</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>James Tully</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Mary Schiner</b>  |  | 13e. STREET ADDRESS<br><b>Baltimore, Md. 842 Arncliffe Rd, 21222</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>--</b>  |  | 17. INFORMANT ADDRESS<br><b>Baltimore, Maryland 21213</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b><br><b>2050</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Severe Anemia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Acute Myelogenous Leukemia</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that <b>Irving Cohen</b> (this hospital) attended the deceased from <b>April 29</b> , 19 <b>82</b> , to <b>April 30</b> , 19 <b>82</b> , that <b>(X)</b> (we) last saw the deceased alive on <b>April 30</b> , 19 <b>82</b> , and that in <b>(our)</b> opinion death occurred on the date and hour and from the causes stated above. <b>(I)</b> (we) (did) (did not) view the body after death.      |  |  |  |  |  |   |  |
| 22b. SIGNATURE <b>Irving Cohen M.D.</b> DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>  |  |  |  | 22c. DATE SIGNED <b>4/30/82</b>  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Irving Cohen M.D.</b>   |  |  |  | 22e. ADDRESS<br><b>9000 Franklin Square Drive 21237</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>May 3, 1982</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>  |  |
| 24. FUNERAL DIRECTOR'S NAME<br><b>Schimunek Funeral Home 3331 Brehms Lane, 21213</b>  |  |  |  | 25a. DATE RECEIVED BY REGISTRAR<br><b>APR 30 1982</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Anna J. [Signature]</b>  |  |

1880

Wm. L. ...  
1880

APR 30 1880  
Wm. L. ...

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE **8 2 0 8 6 8 2**  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |   |   |   |   |  |  |
|---|--|--|---|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  | 2a. DATE OF DEATH   |   |   | 2b. HOUR  |  |  |
| FIRST MIDDLE LAST<br><b>Martha M Karle</b>  |  |  | MONTH DAY YEAR<br><b>April 10 1982</b>                              |   |   | HOUR MIN.<br><b>8:20 PM</b>   |  |  |
| 3. SEX  | 4. RACE  | 5. DATE OF BIRTH   | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |   |   | 7. IF UNDER 1 YEAR  |  |  |
| <b>Female</b>   | <b>Caucasian</b>   | MONTH DAY YEAR<br><b>2-22-1915</b>   | <b>67 yrs.</b>  |   |   | MONTHS DAYS HOURS MIN.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |   |   |   |  |  |
| <b>Balto.</b>   | <b>USA</b>   |  | <b>Baltimore County MD.</b>   |   |   |   |  |  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |   |   | 12b. KIND OF BUSINESS OR INDUSTRY          |  |
| <b>Towson</b>   | <b>St. Joseph Hospital</b>   |  |   | <b>Housewife</b>  |   |   | <b>-</b>                                   |  |
| 13a. STATE  | 13b. COUNTY  | 13c. CITY OR TOWN  | 13d. INSIDE CITY LIMITS?  | 13e. STREET ADDRESS   |   |   |  |  |
| <b>Md.</b>  |  | <b>Balto.</b>  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | <b>3022 Mayfield Avenue 21213</b>                             |   |   |  |  |
| 14. FATHER'S NAME   |  |  | 15. MOTHER'S MAIDEN NAME  |   |   |   |  |  |
| FIRST MIDDLE LAST<br><b>Otto Voss</b>   |  |  | FIRST MIDDLE LAST<br><b>Louise Unknown</b>                          |   |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  | 16b. SOCIAL SECURITY NO.  |   |   | 17. INFORMANT ADDRESS   |  |  |
| <b>no</b>   |  |  | <b>213-80-7335</b>  |   |   | <b>White Hall, Md. 21161</b><br><b>Mary Carr 13 Jordan Mill Court</b> |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>1629</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |  |   |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Chronic Asthma Lung Disease</b>   |  |  |   |   |   |   |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |   | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|   |  |  |   |   |   | YES <input type="checkbox"/> NO <input type="checkbox"/>              |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19          |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |   |  |  |
|   |  |  |   |   |   |   |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>March 29</b> 19 <b>82</b> to <b>April 10</b> 19 <b>82</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>April 10</b> 19 <b>82</b> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) not view the body after death. |  |  |   |   |   |   |  |  |
| 22b. SIGNATURE  |  |  |   |   |   | 22c. DATE SIGNED  |  |  |
|   |  |  |   |   |   |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |   |   |   | 22e. ADDRESS  |  |  |
| <b>E. NAKHODAS M.D.</b>   |  |  |   |   |   | <b>2300 Valley View Rd. 21206</b>                                     |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |  | 23b. DATE   |   | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |  |
| <b>Entombment</b>   |  |  | <b>4-14-82</b>  |   | <b>Gardens of Faith Cem.</b>  |   | <b>Balto., Md.</b>                         |  |
| 24. FUNERAL DIRECTOR'S NAME   |  |  |   |   |   | 25a. DATE REC'D. BY REGISTRAR   |  |  |
| <b>Schimunek Funeral Home, Inc.</b><br><b>3331 Brehms Lane 21213</b>  |  |  |   |   |   | <b>APR 12 1982</b>  |  |  |

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*[Faint handwritten text at bottom]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 6 8 3

|   |  |  |   |                                 |  |
|---|--|--|---|---------------------------------|--|
| 1. FOR STATE REGISTRAR  |  | 2a. DATE OF DEATH  |   | 2b. HOUR                        |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | 2a. DATE OF DEATH  |   | 2b. HOUR                        |  |
| FIRST MIDDLE LAST   |  | MONTH DAY YEAR   |   | HOURS MIN.                      |  |
| DAVIS KAUFMAN.  |  | 04 23 82   |   | 6 16 P.M.                       |  |
| 3. SEX  | 4. RACE  | 5. DATE OF BIRTH   | 6. AGE (IN YEARS LAST BIRTHDAY)                                     | IF UNDER 1 YEAR                 |  |
| MALE  | CAUCASION  | MONTH DAY YEAR   | 87 YRS  | MONTHS DAYS HOURS MIN.          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |                                 |  |
| POLAND  | U.S.A.   |  | BALTIMORE COUNTY MD.  |                                 |  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |                                 |  |
| RANDALLSTOWN  | BALTIMORE COUNTY GENERAL HOSPITAL  | DESIGNER   | PAPER BOXES   |                                 |  |
| 13a. STATE  | 13b. COUNTY  | 13c. CITY OR TOWN  | 13d. INSIDE CITY LIMITS?  | 13e. STREET ADDRESS             |  |
| MARYLAND  |  | BALTIMORE  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 3601 FORDS LA., APT. 717 #21215 |  |
| 14. FATHER'S NAME   | 15. MOTHER'S MAIDEN NAME   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |   |                                 |  |
| JACOB KAUFMAN   | MIREL RUDELNICK  | NO   |   |                                 |  |
| 16b. SOCIAL SECURITY NO.  | 17. INFORMANT  | 18. CAUSE OF DEATH   |   |                                 |  |
| 086-03-5568A  | MR. SAMUEL KAUFMAN   | PART 1. DEATH WAS CAUSED BY:   |   |                                 |  |
| 6210 PARK HGTS AVE., APT. 507 (21215)   |  | IMMEDIATE CAUSE (a) <u>CARDIO-PULMONARY ARREST</u>   |   |                                 |  |
|   |  | 4100   |   |                                 |  |
|   |  | DUE TO, OR AS A CONSEQUENCE OF   |   |                                 |  |
|   |  | (b) <u>ACUTE PULMONARY OEDEMA</u>  |   |                                 |  |
|   |  | DUE TO, OR AS A CONSEQUENCE OF   |   |                                 |  |
|   |  | (c) <u>ACUTE MYOCARDIAL INFARCTION</u>   |   |                                 |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (10)  |  |  |   |                                 |  |
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20a. AUTOPSY?  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |                                 |  |
|   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |                                 |  |
|   | HOUR A.M. MONTH DAY YEAR   |  |   |                                 |  |
|   | P.M. 19  |  |   |                                 |  |
| 21d. INJURY OCCURRED  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    | 21f. LOCATION  |   |                                 |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | STREET CITY OR TOWN COUNTY STATE   |   |                                 |  |
|   |  |  |   |                                 |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>04-23-82</u> to <u>04-23-82</u> , that (I) (we) lost saw the deceased alive on <u>04-23-82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |                                 |  |
| 22b. SIGNATURE  |  | DEGREE   |   | 22c. DATE SIGNED                |  |
| <u>SADPAIN</u>  |  |  |   | 04-23-82                        |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |   |                                 |  |
| DR SUBHIR. PATEL  |  | B. County Gen. Hospital 21133  |   |                                 |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   | 23b. DATE  | 23c. NAME OF CEMETERY OR CREMATORY   | 23d. LOCATION   |                                 |  |
| BURIAL  | 4-25-82  | SHAAREI ZION   | ROSEDALE BALTO. MD STATE  |                                 |  |
| 24. FUNERAL DIRECTOR  |  | 25a. DATE REC'D. BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE      |  |
| SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD., BALTO., MD 21215  |  | APR 28 1982  |   | Francis Jean Nathan             |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 50M 1/81  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |  |                           | 8 2 0 8 6 8 4<br>REG. NO.  |  |
|---|--|--|--|---|--|---|--|--|---------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Felix J KEEPER</b>  |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 3, 1982</b>                                     |  |  | 2b. HOUR<br><b>8:45PM</b> |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 17 1900</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS<br><b>82</b>   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>82</b>  |                           | IF UNDER 24 HRS<br>HOURS MIN.<br><b>82</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County, MD.</b>                            |  |  |                           |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rossville</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Square Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Self Employed</b>        |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Grocery Store</b>                            |                           |  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Edgemere</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>7705 North Cove Road</b>                                   |                           |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Not Known Keeper</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Not Known</b>   |  |   |  |  |                           |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>213-05-3534</b>  |  | 17. INFORMANT<br><b>Raymond Watt</b>  |  | 7705 North Cove Road<br>Balto., MD. 21219   |  |  |                           |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>5860</b><br>IMMEDIATE CAUSE (a) <b>End Stage Renal Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                             |  |  |  |   |  |   |  |  |                           |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |  |  |   |  |   |  |  |                           |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                           | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |  |                           |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NO WHILE AT WORK <input type="checkbox"/>  |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |                           |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>March 24, 1982</b> to <b>April 3, 1982</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>April 3, 1982</b> , and that in (n) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) not view the body after death.) |  |  |  |   |  |   |  |  |                           |  |  |
| 22b. SIGNATURE<br><b>Mohsen Rashdan MD</b>  |  |  |  |   |  |   |  | DEGREE<br><b>MD</b>  |                           | 22c. DATE SIGNED<br><b>4/3/82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Mohsen Rashdan, M.D.</b>  |  |  |  |   |  | 22e. ADDRESS<br><b>9000 Franklin Square Drive 21237</b>   |  |  |                           |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>4/7/1982</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Sacred Ht. Of Jesus</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>                         |  |  |                           |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Duda-Ruck, Inc.<br/>7922 Wise Avenue Dundalk, MD. 21222</b>  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 5 1982</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>James J. [Signature]</b>                            |                           |  |  |

MEDICAL CERTIFICATION

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 6 8 5

|   |  |   |  |
|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  | REG. NO.  |  |
| I. DECEASED NAME<br>(TYPE OR PRINT)   |  | 2a. DATE OF DEATH   |  |
| FIRST MIDDLE LAST<br>EMORY R. KEIL  |  | MONTH DAY YEAR<br>04 23 82  |  |
| 3. SEX<br>MALE  |  | 2b. HOUR<br>11:30 AM  |  |
| 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12 08 14  |  |
| 6. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |  | 7. AGE (IN YEARS LAST BIRTHDAY)<br>67 YRS.  |  |
| 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 10. CITY OR TOWN OF DEATH<br>CATONSVILLE  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.  |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>156 SANFORD AVENUE  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>SUPERVISOR   |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br>DAIRY  |  |   |  |
| 13a. STATE<br>MARYLAND  |  | 13b. COUNTY<br>BALTIMORE  |  |
| 13c. CITY OR TOWN<br>CATONSVILLE  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>GARRY KEIL  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>ALICE L WEBB   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>YES  |  | 16b. SOCIAL SECURITY NO.<br>212-10-9925   |  |
| 17. INFORMANT<br>ADDRESS<br>ADA E. KEIL 156 SANFORD AVENUE, 21228   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u><br>1629<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>CA Lung.</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 DAYS<br>10 Mo. |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c):  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) this hospital attended the deceased from <u>6/24</u> , 19 <u>81</u> , to <u>4/23</u> , 19 <u>82</u> , that (I) <u>we</u> last saw the deceased alive on <u>4/23</u> , 19 <u>82</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.  |  |   |  |
| 22b. SIGNATURE<br><u>Wm C Waterfield M.D.</u>   |  | DEGREE<br>M.D.  |  |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT)<br>WILLIAM C. WATERFIELD, M.D.  |  | 22d. ADDRESS<br>ST. AGNES HOSPITAL, ONCOLOGY DEPT.  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  | 23b. DATE<br>04-27-82   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br>LOUDON PARK   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE CITY MARYLAND   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>HUBBARD FUNERAL HOME, INC.  |  | 25a. DATE REC'D. BY REGISTRAR<br>APR 26 1982  |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>Thomas J. [Signature]</u>  |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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APR 30 1985

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 6 8 6

REG. NO.

|  |  |  |  |  |  |   |  |                              |  |                  |  |        |  |      |  |          |  |
|--|--|--|--|--|--|---|--|------------------------------|--|------------------|--|--------|--|------|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST  |  | MIDDLE   |  | LAST  |  | 2a. DATE OF DEATH            |  | MONTH            |  | DAY    |  | YEAR |  | 2b. HOUR |  |
| Joshua W. Keller   |  |  |  |  |  |   |  | April 30, 1982               |  |                  |  |        |  |      |  | 1:50A.M. |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR              |  | IF UNDER 24 HRS. |  | MONTHS |  | DAYS |  | HOURS    |  |
| Male   |  | White  |  | April 30 1982  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | YRS.                         |  | 1                |  |        |  |      |  |          |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                              |  |                  |  |        |  |      |  |          |  |
| Maryland   |  | U.S.A.   |  |  |  | Baltimore County  |  |                              |  |                  |  |        |  |      |  |          |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                              |  |                  |  |        |  |      |  |          |  |
| Rossville  |  | Franklin Square Hospital   |  | Dependent  |  |   |  |                              |  |                  |  |        |  |      |  |          |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS          |  |                  |  |        |  |      |  |          |  |
| Maryland   |  | Baltimore  |  | Baltimore  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 21206<br>5220 Frankford Ave. |  |                  |  |        |  |      |  |          |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |   |  |                              |  |                  |  |        |  |      |  |          |  |
| FLOYD D. KELLER JR.  |  | DIANE M. CARTER  |  |  |  |   |  |                              |  |                  |  |        |  |      |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)  |  | 17. INFORMANT  |  | ADDRESS   |  |                              |  |                  |  |        |  |      |  |          |  |
| No   |  | None   |  | Diane M. Fleetwood   |  | 5220 Frankford Ave.   |  |                              |  |                  |  |        |  |      |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Hypoxia secondary to Tension Pneumothorax</u><br>7702<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |   |  |                              |  |                  |  |        |  |      |  |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____  |  |  |  |  |  |   |  |                              |  |                  |  |        |  |      |  |          |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |                              |  |                  |  |        |  |      |  |          |  |
|  |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |                              |  |                  |  |        |  |      |  |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |                              |  |                  |  |        |  |      |  |          |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |                              |  |                  |  |        |  |      |  |          |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 30, 1982, to April 30, 1982, that <input checked="" type="checkbox"/> (we) lost<br>saw the deceased alive on April 30, 1982, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated<br>above <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> (we) did not view the body after death. |  |  |  |  |  |   |  |                              |  |                  |  |        |  |      |  |          |  |
| 22b. SIGNATURE<br><i>Steven M. Wilk, MD</i>  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>April 30, 1982   |  |   |  |                              |  |                  |  |        |  |      |  |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Steven Wilk, MD   |  | 22e. ADDRESS<br>9000 Franklin Sq. Dr., Balto., MD 21237  |  |  |  |   |  |                              |  |                  |  |        |  |      |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |  |                              |  |                  |  |        |  |      |  |          |  |
| Burial   |  | May 4 1982   |  | Holy Redeemer Cem.   |  | Baltimore Maryland  |  |                              |  |                  |  |        |  |      |  |          |  |
| 24. FUNERAL DIRECTOR<br>NAME   |  | ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |                              |  |                  |  |        |  |      |  |          |  |
| Leonard J. Ruck, Inc.  |  | Baltimore, Maryland  |  | MAY 3 1982   |  | <i>James J. Smith</i>   |  |                              |  |                  |  |        |  |      |  |          |  |

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*Handwritten signature*  
MAY 6 1961



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |  |  |  |  |  | REG. NO. 8 2 0 8 6 8 7                                     |  |  |  |
|--|--|---|--|--|--|--|--|--|--|--|--|--|--|
| 1- FOR STATE REGISTRAR   |  | 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>CORDIE TAYLOR KELLY  |  |  |  |  |  | 2a DATE OF DEATH MONTH DAY YEAR<br>4-28-82 2 31 PM   |  |  |  |  |  |
| 3 SEX<br>Female  |  | 4 RACE<br>Black   |  | 5 DATE OF BIRTH MONTH DAY YEAR<br>Aug. 22, 1898  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>83 YRS.  |  | 7b CITIZEN OF WHAT COUNTRY?<br>USA   |  | 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Northumberland |  |  |  |
| 10 CITY OR TOWN OF DEATH<br>Balto.   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Balto. County General Hosp. |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore CO. MD.                                      |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b KIND OF BUSINESS OR INDUSTRY                           |  |  |  |
| 13a STATE<br>Md.   |  | 13b COUNTY<br>Balto.  |  | 13c CITY OR TOWN<br>Balto.   |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e STREET ADDRESS<br>1630 Gwynns Fall Pkwy.   |  |  |  |  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>Travis Taylor  |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Jennie Jessup  |  | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |  | 16b SOCIAL SECURITY NO.<br>215-09-3434   |  | 17 INFORMANT<br>Yvonne Pinkard   |  | ADDRESS<br>1630 Gwynn Falls Pkwy.                          |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>MULTIFACTORIAL CAUSE</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>CACHEXIA</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Dehydration</u>  |  |   |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH               |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>RENAL FAILURE, URINARY TRACT INFECTION, POSSIBLE ST MAIGNANT</u>  |  |   |  |  |  |  |  |  |  |  |  |  |  |
| 19a DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4-17-82</u> 19 <u>82</u> , to <u>4-28-82</u> 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>4-28</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><i>[Signature]</i>   |  | DEGREE  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                 |  |  |  | 22c. DATE SIGNED<br>4-28-82  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ORLANDO B. CONNAN, MD   |  | 22e. ADDRESS<br>BETH - RANDOLFTOWN MD. 21133  |  |  |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>5/3/82   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Balto. Nat. Cem.   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto., Md.                                      |  |  |  |  |  |  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>LEROY O. DYETT  |  | ADDRESS<br>4600 LIBERTY HGTS AVE.   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 3 1982  |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |  |  |  |  |  |  |

MEDICAL CERTIFICATION

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1304 BP

1960 11 18

100-44388-1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 6 8 8

REG. NO.

|   |  |  |  |   |  |   |  |  |  |
|---|--|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  | 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST MIDDLE LAST<br>Elizabeth D. Kelly   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>April 10, 1982   |  | 2b. HOUR<br>5:00 PM  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Sept. 12 1922   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>59 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                    |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Owings Mills   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>21 Richmar Road |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>Owings Mills   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>21 Richmar Road   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>James Martin Amoss  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Nellie May Burton  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>214-16-6206   |  | 17. INFORMANT<br>ADDRESS<br>Frank J. Flaherty 8340 Oakleigh Road  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u><br><u>1629</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Cerebral Vascular Accident</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(c) <u>Lung Cancer with Metastatic Spread</u> |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Sandra L. Howard M.D.</u>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |   |  | 22c. DATE SIGNED<br><u>April 12, 1982</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Sandra L. Howard, M.D.   |  |  |  | 22e. ADDRESS<br>South Baltimore General Hospital  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>Apr. 14, 1982   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Moreland Mem. Park  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland                                |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Leonard J. Ruck, Inc. Baltimore, Maryland   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>APR 13 1982  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Anna J. [Signature]</u>  |  |  |  |

1900

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 2 0 8 6 8 9  
CERTIFICATE OF DEATH

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |   |   |   |  |   |
|---|---|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>FRANCES K. Kerch  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>4-16-82  |  | 2b. HOUR<br>1:55 A.M.   |
| 3. SEX<br>FEMALE  | 4. RACE<br>W  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3 7 11  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>71 YRS                                      | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>PA.   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE County MD.                   |   |
| 10. CITY OR TOWN OF DEATH<br>RANDALLSTOWN   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>BALD. CO. GEN. Hosp. |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE.                  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |
| 13a. STATE<br>MD.   |   | 13b. CITY OR TOWN<br>BALTO. Pikesville  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13d. STREET ADDRESS<br>219 McHENRY AVE.  |   |
| 14. FATHER'S NAME<br>VALENTINE  |   | 15. MOTHER'S MAIDEN NAME<br>MARY WROBLESKI  |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) NO        |   |
| 16b. SOCIAL SECURITY NO.<br>220-03-4312   |   | 17. INFORMANT<br>ELMER E. KERCH   |   | ADDRESS<br>SAME 21208  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac arrest</u><br>4029<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertensive cardiovascular disease</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Paraneoplastic gastric carcinoma</u>  |   |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)<br><u>Paraneoplastic gastric carcinoma</u>   |   |   |   |  |   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |
| 22a. I certify that (1) <u>Samuel P. Scalia</u> attended the deceased from <u>9-2</u> , 19 <u>69</u> , to <u>4-15</u> , 19 <u>82</u> , that (1) <u>he</u> last saw the deceased alive on <u>4-9</u> , 19 <u>82</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above; (2) <u>he</u> (did/did not) view the body after death. |   |   |   |  |   |
| 22b. SIGNATURE<br><u>Samuel P. Scalia, MD</u>   |   |   |   | 22c. DATE SIGNED<br>4-16-82  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>SAMUEL P. SCALIA   |   | 22e. ADDRESS<br>7 CHURCH LANE BALTO MD  |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(CHECK)<br>BURIAL  |   | 23b. DATE<br>4-20-82  | 23c. NAME OF CEMETERY OR CREMATORY<br>ST. BARBARA CEM.  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>HOUTZDALE PA.   |
| 24. FUNERAL DIRECTOR<br>NAME<br>NEWELL F.H.   |   | ADDRESS<br>1100 REASTOWN RD   |   | 25a. DATE REC'D. BY REGISTRAR<br>APR 23 1982                                   |   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed in the office of the funeral director, page 3 with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 6 9 0

REG. NO.

|  |  |  |  |   |   |   |  |  |   |
|--|--|--|--|---|---|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Dorothy Mary Kerger   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>April 27, 1982                  |   |   | 2b. HOUR<br>11:00 PM  |  |  |   |
| 3. SEX<br>Female   |  | 4. RACE<br>Caucasian   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Nov. 29, 1908   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>73 YRS   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                    |  |  |   |
| 10. CITY OR TOWN OF DEATH<br>Catonsville   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>15 Newburg Avenue |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Operator                    |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Telephone   |   |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>Catonsville  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>15 Newburg Avenue 21228   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Maurice S. Hyland  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Elizabeth McLaughlin   |   |   |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>N/A   |  | 212-05-0222   |   | 17. INFORMANT<br>ADDRESS<br>Mrs. Helen H. Hyland Same as # 13                                   |  |  |   |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Chronic obstructive pulmonary disease</u><br>4960<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>with cor pulmonale.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>5 yr. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><u>Esophageal structure.</u>   |  |  |  |   |   |   |  |  |   |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET<br>CITY OR TOWN<br>COUNTY<br>STATE                                      |  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10/15</u> , 19 <u>66</u> , to <u>4/27</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>4/20</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.  |  |  |  |   |   |   |  |  |   |
| 22b. SIGNATURE<br><u>Morton M. Krieger</u>   |  |  |  |   |   | DEGREE<br>M.D.  |  | 22c. DATE SIGNED<br>4/29/82  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Morton M. Krieger, M.D.   |  |  |  |   |   | 22e. ADDRESS<br>606 Hammonds Lane Balt., Md. 21225  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |  | 23b. DATE<br>4/30/82   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>St. Mary's Cemetery |   | 23d. LOCATION<br>CITY OR TOWN<br>COUNTY<br>STATE<br>Illchester Howard, Md. |  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>MacNabb Funeral Home   |  |  |  |   |   | 25a. DATE RECD. BY REGISTRAR<br>APR 30 1982   |  |  |   |
| ADDRESS<br>Catonsville, Md.  |  |  |  |   |   | 25b. REGISTRAR'S SIGNATURE<br><u>James J. North</u>   |  |  |   |

1992-1993



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 6 9 1

REG. NO.

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Charles A. Kerin  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>4 23 82 |   |  | 2b. HOUR<br>1:12pm   |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8 30 05   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>76 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Vermont   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore, County MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>Catonsville   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Little Sisters of the Poor |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Priest  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Catonsville  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 13e. STREET ADDRESS<br>St. Charles Villa   |  | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Daniel P. Kerin   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Marie Rose Flanagan  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Unknown no   |  | 16b. SOCIAL SECURITY NO.<br>363-60-6598   |  | 17. INFORMANT<br>ADDRESS<br>Sr. Martha 601 Malden Choice Lane   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Massive Cerebral Vase. Accident.</u><br><u>4360</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <u>Gangrene of st. leg.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>History of previous death</u> |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2.19.77</u> 19 <u>77</u> , to <u>4.23</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>4.21</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Stanley Ankrutz</u>   |  | DEGREE<br>M.D.  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br><u>4.24.82</u>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>STANLEY ANKRUTZ   |  | 22e. ADDRESS<br>1101 Malden Choice Ln. Bost. 21234  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>Apr. 27, 1982  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>St. Charles   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Catonsville Baltimore MD.  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Leonard J. Ruck Inc. Baltimore, Maryland   |  |   |  | 25a. DATE RECEIVED BY REGISTRAR<br>APR 27 1982  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 2 0 8 6 9 2  
CERTIFICATE OF DEATH

|  |   |             |   |  |                                      |  |                 |  |                  |  |  |
|--|---|-------------|---|--|--------------------------------------|--|-----------------|--|------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |   | FIRST       | MIDDLE  | LAST   | 2a. DATE OF DEATH                    |  | MONTH           | DAY  | YEAR             | 2b. HOUR   |  |
| ABNER  |   | S.          | KIEL  |  | APRIL 26, 1982                       |  |                 |  |                  | M  |  |
| 3. SEX   | 4. RACE   |             | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)      |  | IF UNDER 1 YEAR |  | IF UNDER 24 HRS. |  |  |
| Male   | White   |             | MONTH DAY YEAR<br>6 6 1901  |  | 80 YRS.                              |  | MONTHS DAYS     |  | HOURS MIN.       |  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?  |             | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |                 |  |                  |  |  |
| Alabama  | USA   |             |   |  | Baltimore County MD.                 |  |                 |  |                  |  |  |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY    |  |                 |  |                  |  |  |
| Edgemere   | 7333 Geis Avenue  |             | Steel Worker  |  | Beth. Steel                          |  |                 |  |                  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |   |             |   |  |                                      |  |                 |  |                  |  |  |
| 13a. STATE   |   | 13b. COUNTY |   | 13c. CITY OR TOWN  |                                      | 13d. INSIDE CITY LIMITS?   |                 | 13e. STREET ADDRESS  |                  |  |  |
| Maryland   |   | Baltimore   |   | Edgemere   |                                      | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                 | 7333 Geis Avenue   |                  |  |  |
| 14. FATHER'S NAME  |   |             |   | 15. MOTHER'S MAIDEN NAME   |                                      |  |                 |  |                  |  |  |
| FIRST MIDDLE LAST  |   |             |   | FIRST MIDDLE LAST  |                                      |  |                 |  |                  |  |  |
| Harry Kiel   |   |             |   | Mattie Lockett   |                                      |  |                 |  |                  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |   |             |   | 16b. SOCIAL SECURITY NO.   |                                      | 17. INFORMANT  |                 | ADDRESS  |                  |  |  |
| No   |   |             |   | 213-07-3817  |                                      | Abner D. Kiel  |                 | 7333 Geis Avenue<br>Balto., MD. 21219  |                  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u><br><u>4960</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |   |             |   |  |                                      |  |                 |  |                  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |   |             |   |  |                                      |  |                 |  |                  |  |  |
| 19a. DATE OF OPERATION   |   |             |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                      |  |                 | 20a. AUTOPSY?  |                  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|  |   |             |   |  |                                      |  |                 | YES <input type="checkbox"/> NO <input type="checkbox"/>   |                  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |   |             |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |                 |  |                  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |   |             |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                      | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                 |  |                  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/5/82</u> 19 <u>82</u> to <u>4/27/82</u> 19 <u>82</u> that (I) (we) last saw the deceased alive on <u>4/21/82</u> 19 <u>82</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |   |             |   |  |                                      |  |                 |  |                  |  |  |
| 22b. SIGNATURE<br><u>Lope T. Villa Jr.</u>   |   |             |   | DEGREE<br>M.D.   |                                      |  |                 | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                  | 22c. DATE SIGNED<br><u>4/27/82</u>                             |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Lope T. Villa, Jr. M.D.   |   |             |   | 22e. ADDRESS<br>7600 Osler Drive Suite 211                             |                                      |  |                 |  |                  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |   |             |   | 23b. DATE  |                                      | 23c. NAME OF CEMETERY OR CREMATORY   |                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |                  |  |  |
| Burial   |   |             |   | 4/29/1982  |                                      | St. Jacob  |                 | Fairfield Penn.  |                  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME   |   |             |   |  |                                      | ADDRESS  |                 | 25a. DATE REC'D. BY REGISTRAR  |                  |  |  |
| Duda-Ruck Funeral Home of Dundalk, Inc.  |   |             |   |  |                                      |  |                 | 25b. REGISTRAR'S SIGNATURE<br><u>James Jean Nathan</u>   |                  |  |  |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                       |  |  |  |   |  |   |  | REG. NO. 08693  |  |   |  |
|---|--|-----------------------|--|--|--|---|--|---|--|---|--|---|--|
| 1- STATE REGISTRAR  |  |                       |  |  |  |   |  |   |  |   |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>Marjorie M. Kielian  |  |                       |  |  |  |   |  |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED<br>April 14, 1982                                |  | 2b. HOUR<br>11:30 PM  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White      |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Sept. 15, 1906   |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br>75 YRS.   |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN   |  | 2c. DATE PRONOUNCED DEAD<br>April 14, 1982  |  | 2d. HOUR<br>11:30 PM  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  |                       |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD                           |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  |                       |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1202 Deanwood Road 21234 |  |   |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Dentist Ass. Retired |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |                       |  |  |  |   |  |   |  |   |  |   |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>County |  | 13c. CITY OR TOWN<br>Baltimore   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>1202 Deanwood Road 21234   |  |   |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>George Kielian  |  |                       |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Maryanna Giza                                  |  |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No   |  |                       |  | 16b. SOCIAL SECURITY NO.<br>220-07-9249-A  |  | 17. INFORMANT<br>ADDRESS<br>Mr. Joseph A. Kielian, 1202 Deanwood Rd. 21234                      |  |   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I DEATH WAS CAUSED BY:<br>4049 IMMEDIATE CAUSE (a) Cordae Arrest<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) Hypertension<br>(c) DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>Sudden<br>5 yrs.                      |  |                       |  |  |  |   |  |   |  |   |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1  |  |                       |  |  |  |   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  |                       |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |   |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                       |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |                       |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion: |  |                       |  |  |  |   |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE<br>Charles F. O'Donnell  |  |                       |  | TITLE (SPECIFY)<br>Deputy  |  |   |  | MEDICAL EXAMINER  |  |   |  | DATE SIGNED<br>4/14/82  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Charles F. O'Donnell, M.D.  |  |                       |  | ADDRESS<br>7501 York Road, Towson, Md. 21204   |  |   |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |                       |  | 23b. DATE<br>April 17, 1982  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>St. Stanislaus Cemetery                                   |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland                     |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>M.F. Sadowski & Sons  |  |                       |  | ADDRESS<br>1808 Eastern Ave. 21231   |  |   |  | 25. DATE REC'D. BY REGISTRAR<br>APR 19 1982   |  |   |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and report.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 6 9 4

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|   |  |  |   |   |  |  |  |
|---|--|--|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>ANNA H KIEVAL   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>4/3/82                 |   |  | 2b. HOUR<br>6A   |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>May 12, 1899  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>82  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>New York   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>PIKESVILLE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>PIKESVILLE NURSING HOME |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>AT HOME   |  |
| 13a. STATE<br>Md  |  | 13b. COUNTY<br>BALTIMORE   |   | 13c. STREET ADDRESS<br>APT. 318 #21215<br>2500 W. BELVEDERE AVE   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>BENJAMIN OOHEN  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>TEMA UNKNOWN |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>214-18-2289   |   | 17. INFORMANT<br>ADDRESS<br>JEROME LIPMAN - 6018 Woodcrest Ave 21209  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) ASCVD<br>4148<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Hypertensive Cardiovascular/Coronary D.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>years |  |  |   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>Chronic Renal Failure / CAD - myo inf / CHF / Polytrauma Vena.   |  |  |   |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/24/1982 to 4/3/1982, that (I) (we) lost saw the deceased alive on 3/24/1982 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.                               |  |  |   |   |  |  |  |
| 22b. SIGNATURE<br>COCHRAN   |  |  |   |   |  | 22c. DATE SIGNED<br>4/3/82   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>COCHRAN  |  |  |   | 22e. ADDRESS<br>6506 PARK HEIGHTS AVE, BALD 21215   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE OR PRINT)<br>BURIAL  |  | 23b. DATE<br>APRIL 4/8-  |   | 23c. NAME OF CEMETERY OR CREMATOR<br>Beth Isaac Adath   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE MD   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Sol Lennier & Sons - 6010 Reisterstown Rd   |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>APR 8 1982   |  |  |  |

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 6 9 5

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |   |   |   |   |  |
|--|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><i>Mary Elizabeth Kilduff</i>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>04-02-82</i>                                |   | 2b. HOUR<br>M<br><i></i>   |
| 3. SEX<br><i>Female</i>  | 4. RACE<br><i>White</i>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>04 06 19</i>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>62</i>  | IF UNDER 1 YEAR<br>MONTHS DAYS<br><i></i>  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Newark, N. Jersey</i>  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore County</i> MD.                               |  |
| 10. CITY OR TOWN OF DEATH<br><i>Pikesville</i>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Pikesville Nursing Home</i> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Home Maker</i> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>-----</i>  |
| 13a. STATE<br><i>Maryland</i>  |   |   | 13b. COUNTY<br><i>Baltimore</i>   | 13c. CITY OR TOWN<br><i>Randallstown</i>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Raymond J. Boyle</i>  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Mae Anberg</i>                    |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i>  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><i>135-01-0271</i>   |   | 17. INFORMANT<br><i>Randallstown, Md. 21133</i><br><i>Francis X. Kilduff, 3715 Elkanah Place,</i> |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Brain Metastases</i><br><i>1749</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Breast Cancer</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>4 years</i> |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>4 years</i>   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |   |   |   |   |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>              | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                    |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>3-17</i> , 19 <i>82</i> , to <i>4-2</i> , 19 <i>82</i> , that (I) (we) last saw the deceased alive on <i>3-31</i> , 19 <i>82</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.  |   |   |   |   |  |
| 22b. SIGNATURE<br><i>Harold B. Bob</i> DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |   |   |   | 22c. DATE SIGNED<br><i>4-5-82</i>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Harold B. Bob</i>  |   | 22e. ADDRESS<br><i>M.D. 7220 Park Heights Avenue, Baltimore, Md. 21208</i>  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>   |   | 23b. DATE<br><i>April 7, 82</i>   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Arlington National Cem</i>                   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Arlington Arlington VA.</i>   |
| 24. FUNERAL DIRECTOR<br><i>Loring Byers Funeral Directors Inc.</i>   |   |   | 25a. DATE REC'D. BY REGISTRAR<br><i>APR 5 1982</i>                                    |   |  |
| 25b. REGISTRAR'S SIGNATURE<br><i>James J. Nathan</i>   |   |   |   |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8208696

REG. NO.

|  |  |  |  |   |  |   |  |   |  |
|--|--|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>WAYNE W. KING  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>April 12, 1982      |   | 2b. HOUR<br>MIN.<br>12 45 P  |   |  |   |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>May 23, 1899  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>82 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Ohio   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                    |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Towson  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>803 Kingston Road |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Sales Engineer   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Machinery   |   |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>Towson   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>803 Kingston Road                        |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William T. King  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Justina ? |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WW I & II   |  | 17. INFORMANT<br>Mrs. Louise K. Mitchell,   |  | ADDRESS<br>Same   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CANCER OF THE COLON: ACUTE MYELOGENOUS 4 MONTHS</u><br><u>1539</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/11</u> , 19 <u>82</u> , to <u>4/12</u> , 19 <u>82</u> , that (I) (we) lost<br>saw the deceased alive on <u>4/11</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                               |  |  |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><u>Lydia M. Jumamoy, M.D.</u>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br><u>4/12/82</u>  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Lydia Jumamoy, M.D.   |  |  |  | 22e. ADDRESS<br>Church Hospital, Balto., Md.  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation  |  | 23b. DATE<br>4/13/82   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Green Mount   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. Md.  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Henry W. Jenkins & Sons Co.<br>4905 York Road Balto., Md. 21212  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>APR 13 1982  |  |   |  |   |  |

April 12, 1942

Dear Sir:

Re:

Enclosed for you are

U.S.

of

for a further statement

of the situation

and

in the event of

the situation

and

Yours truly,

Very

Very

Very truly yours,  
[Signature]

Enclosed for you are

Yours truly,

0 0 0 0 0 0 0

0 0 0 0 0 0 0

Very truly yours,

Very truly yours,

Very truly yours,  
[Signature]

Very truly yours,

Very truly yours,

Very truly yours,

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                                 |  |  |  |   |  |   |  | REG. NO. 8 2 0 8 6 9 7  |  |
|---|--|---------------------------------|--|--|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  |                                 |  |  |  |   |  |   |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Olin C. Kirby</b>  |  |                                 |  |  |  | 2b. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/>       |  | 26. HOUR <input type="checkbox"/>   |  |   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>         |  | 5. DATE OF BIRTH<br>MONTH <b>9</b> DAY <b>23</b> YEAR <b>07</b>  |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY) <b>74</b> YRS.   |  | IF UNDER 1 YR. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>          |  | IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>  |  |                                 |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County, MD.</b>                  |  | 2c. DATE PRONOUNCED DEAD<br>MONTH <b>4</b> DAY <b>29</b> YEAR <b>1982</b>         |  |
| 10. CITY OR TOWN OF DEATH<br><b>Catonsville</b>   |  |                                 |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>424 Maryland Avenue</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Aide</b>          |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Hospital</b>                              |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b> |  | 13c. CITY OR TOWN<br><b>Catonsville</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>424 Maryland Avenue</b>                                     |  |   |  |
| 14. FATHER'S NAME<br>FIRST <input type="checkbox"/> MIDDLE <input type="checkbox"/> LAST <input type="checkbox"/>   |  |                                 |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <input type="checkbox"/> MIDDLE <input type="checkbox"/> LAST <input type="checkbox"/>                 |  |   |  | 16. ADDRESS<br><b>Lula Ann Kirby</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>n/a</b>  |  |                                 |  | 16b. SOCIAL SECURITY NO.<br><b>220-36-0632</b>   |  | 17. INFORMANT<br><b>records</b>   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH CAUSED BY:<br><b>9554 IMMEDIATE CAUSE (a) Gunshot wound of head</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <input type="checkbox"/> DUE TO, OR AS A CONSEQUENCE OF<br>(c) <input type="checkbox"/> DUE TO, OR AS A CONSEQUENCE OF  |  |                                 |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                      |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |                                 |  |  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  |                                 |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |   |  | 20. HEAD ONLY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                                 |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>4 29 1982</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>Self inflicted</b>  |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK  |  |                                 |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>home</b>   |  | 21f. LOCATION<br>STREET <b>424 Maryland Ave.,</b> CITY OR TOWN <b>Catonsville,</b> COUNTY <b>Balto.,</b> STATE <b>Md.</b>                                   |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from <input checked="" type="checkbox"/> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .<br>Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion. |  |                                 |  |  |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE<br><b>Thomas D. Smith</b>  |  |                                 |  | TITLE (SPECIFY)<br><b>Deputy Chief</b>   |  |   |  | DATE SIGNED<br><b>4/30/82</b>   |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Thomas D. Smith, M.D.</b>   |  |                                 |  | ADDRESS<br><b>111 Penn St. Balto., MD.</b>   |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>burial</b>  |  |                                 |  | 23b. DATE<br><b>5/3/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Roselawn Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN <b>Marion</b> COUNTY <b>Smith</b> STATE <b>Virginia</b> |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Marzullo Fineral Service</b>   |  |                                 |  | ADDRESS<br><b>238 Hartley Drive</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 3 1982</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>James J. [Signature]</b>                             |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |        |   |                   |                           |       | REG. NO. 8 2 0 8 6 9 8                              |      |           |
|--|--|--|--|--|--------|---|-------------------|---------------------------|-------|---|------|-----------|
| 1. FOR STATE REGISTRAR   |  | 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST  | MIDDLE | LAST  | 2a. DATE OF DEATH |                           | MONTH | DAY   | YEAR | 2b. HOUR  |
|  |  | WALTER KIRSON  |  |  |        |   | APRIL 3, 1982     |                           |       |   |      | 5:45 P.M. |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |        | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |                   | IF UNDER 1 YEAR           |       | IF UNDER 74 HRS.                                    |      |           |
| MALE   |  | WHITE  |  | FEB. 21, 1912  |        | 70 YRS.   |                   | MONTHS                    |       | DAYS  |      |           |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |        | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |                   |                           |       |   |      |           |
| MARYLAND   |  | USA  |  |  |        | BALTIMORE COUNTY  |                   |                           |       | MD.   |      |           |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |        | 12b. KIND OF BUSINESS OR INDUSTRY                                   |                   |                           |       |   |      |           |
| PIKESVILLE   |  | 3313 MIDFIELD RD. (21208)  |  | PHARMACIST   |        | DRUGS   |                   |                           |       |   |      |           |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |        | 13d. INSIDE CITY LIMITS?  |                   | 13e. STREET ADDRESS       |       |   |      |           |
| MARYLAND   |  | BALTIMORE  |  | PIKESVILLE   |        | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                   | 3313 MIDFIELD RD. (21208) |       |   |      |           |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |        | 16b. SOCIAL SECURITY NO.  |                   | 17. INFORMANT             |       | ADDRESS   |      |           |
| SAMUEL   |  | ANNIE  |  | NO   |        | 219-30-5534   |                   | MRS. HATTIE KIRSON        |       | 3313 MIDFIELD RD. (21208)                           |      |           |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)                          |  | 4140   |  | DUE TO, OR AS A CONSEQUENCE OF   |        | Arteriosclerotic heart disease                                      |                   | Compensatory failure      |       | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH        |      |           |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |  | DUE TO, OR AS A CONSEQUENCE OF   |        |   |                   |                           |       |   |      |           |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                |  | Chronic obstructive lung disease   |  |  |        |   |                   |                           |       |   |      |           |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |        | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |                   |                           |       |   |      |           |
|  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |        | YES <input type="checkbox"/> NO <input type="checkbox"/>            |                   |                           |       |   |      |           |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)   |        |   |                   |                           |       |   |      |           |
|  |  | HOUR A.M. MONTH DAY YEAR   |  |  |        |   |                   |                           |       |   |      |           |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION  |        |   |                   |                           |       |   |      |           |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  | STREET   |        | CITY OR TOWN  |                   | COUNTY                    |       | STATE   |      |           |
| 22a. I certify that (I) (this hospital) attended the deceased from   |  | 313  |  | 6/26   |        | 19 81   |                   | to 4/3                    |       | 19 82, that (I) (we) last saw the deceased alive on |      |           |
| above, (I) (we) did not view the body after death.   |  |  |  |  |        |   |                   |                           |       |   |      |           |
| 22b. SIGNATURE   |  | DEGREE   |  | 22c. DATE SIGNED   |        |   |                   |                           |       |   |      |           |
| H. Ronald Friedman   |  | MD   |  | 4/5/82   |        |   |                   |                           |       |   |      |           |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  | 22f. DATE REC'D. BY REGISTRAR  |        | 22g. REGISTRAR'S SIGNATURE  |                   |                           |       |   |      |           |
| H. RONALD FRIEDMAN   |  | 6715 PARK HEIGHTS AVE. (21215)   |  | APR 8 1982   |        | Name Jan [Signature]  |                   |                           |       |   |      |           |
| 23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |        | 23d. LOCATION   |                   |                           |       |   |      |           |
| BURIAL   |  | 4-5-82   |  | HEBREW YOUNG MENS CEM.   |        | BALTO. COUNTY, MD.  |                   |                           |       |   |      |           |
| 24. FUNERAL DIRECTOR   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |        |   |                   |                           |       |   |      |           |
| NAME SOL LEVINSON & BROS   |  | APR 8 1982   |  | Name Jan [Signature]   |        |   |                   |                           |       |   |      |           |
| 6010 REISTERSTOWN RD. BALTIMORE, MD. (21215)   |  |  |  |  |        |   |                   |                           |       |   |      |           |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |   |  | 8 2 0 8 6 9 9<br>REG. NO.  |                            |  |  |
|--|--|--|--|---|--|--|--|---|--|--|----------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST<br><i>Helen</i>  |  | MIDDLE<br><i>R</i>  |  | LAST<br><i>Kisamore</i>  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>4-14-82</i>                     |  |  | 2b. HOUR<br><i>1:15</i> AM |  |  |
| 3. SEX<br><i>female</i>  |  | 4. RACE<br><i>white</i>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>Sept. 13, 1919</i>   |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS HOURS MIN.<br><i>62</i>                    |   |  | IF UNDER 1 YEAR<br>IF UNDER 1 YEAR   |                            |  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><i>Arkansas</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore County</i> MD.                            |   |  |  |                            |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Randallstown</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Balto. County General Hospital</i> |  |   |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Ret/ School Teacher</i> |   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |                            |  |  |
| 13a. STATE<br><i>MD</i>  |  | 13b. COUNTY<br><i>Balto.</i>   |  | 13c. CITY OR TOWN<br><i>Randallstown</i>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS<br><i>8619 Lugano Rd.</i>                             |  |  |                            |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Robert N. Reynolds</i>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Mary Belle Belin</i>  |  |  |  |   |  |  |                            |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>Yes</i>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><i>W.W. II 430-34-3790</i>  |  | 17. INFORMANT<br><i>Mr. Ken Kisamore</i>  |  |  |  | 8619 Lugano Rd.<br><i>Randallstown, Md. 21133</i>                         |  |  |                            |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Multiple Sclerosis</i><br><i>3400</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <i>Urinary tract infection with septicemia</i><br>(c) <i>Diabetes mellitus</i><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>4 years</i><br><i>weeks</i><br><i>years</i> |  |  |  |   |  |  |  |   |  |  |                            |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |  |  |   |  |  |                            |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                            |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |   |  |  |                            |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |                            |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>3-31-1982</i> to <i>4-14-1982</i> , that (I) (we) last saw the deceased alive on <i>4-14-1982</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |  |   |  |  |                            |  |  |
| 22b. SIGNATURE<br><i>Soonchul Hong</i>   |  |  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><i>4-14-82</i>  |  |  |                            |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>SOONCHUL HONG</i>  |  |  |  |   |  | 22e. ADDRESS<br><i>Baltimore County General Hospital</i>   |  |   |  |  |                            |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>  |  | 23b. DATE<br><i>4/17/82</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Lake View Mem. Park</i>  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Eldersburg Carroll MD</i>                     |   |  |  |                            |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Loring Byers Funeral Directors</i><br>ADDRESS<br><i>8728 Liberty Rd. Randallstown, Md. 21133</i>  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><i>APR 16 1982</i>  |  |   |  |  |                            | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i> |  |

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2/20/74

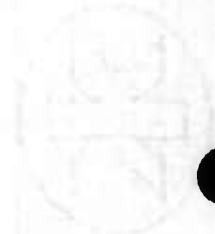
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 7 0 0

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>JOHN G. KLESS SR.</b>  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4/7/82</b>  |  | 2b. HOUR<br>MIN<br><b>6:55P</b>   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Feb. 18, 1902</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><b>80</b>                                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Balto. Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>TOWSON Balto. Co. MD.</b>                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT NURSING FACILITY, GIVE STREET ADDRESS)<br><b>6701 N CHARLES ST GBMC</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired Builder</b>      |  |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>Balto.</b>   |  | 13c. CITY OR TOWN<br><b>Towson</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John J. Klass</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ida Lee</b>  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>217-01-5806</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Doris E. Koenig Reisterstown, Md.</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ASPIRATION PNEUMONIA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>CARCINOMA OF LUNG</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |  |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>MARCH 14, 1982</b> , to <b>APRIL 7, 1982</b> , that (I) (we) lost<br>saw the deceased alive on <b>APRIL 7, 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.         |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Samuel L. Jacobs</b>   |  |  |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>4/7/82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR S JACOBS</b>   |  |  |  | 22e. ADDRESS<br><b>GBMC</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>April 10, 82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moreland Memorial</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md.</b>                             |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Eline Funeral Home Reisterstown, Md. 21136</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 8 1982</b>  |  |   |  |
|   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Thom Jan North</i>   |  |   |  |

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TO: DIRECTOR, FBI  
FROM: SAC, NEW YORK  
SUBJECT: [illegible]  
RE: [illegible]

ADMINISTRATIVE PAGE TWO

APRIL 11 1964  
[illegible text]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 2 0 8 7 0 1  
REG. NO.

|  |   |   |  |  |  |
|--|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Elsie</b> <b>m.</b> <b>Kopper.</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4-12-82</b>                                |  | 2b. HOUR<br><b>7 AM</b>  |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12/24/05</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>76</b> YRS.                              | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>md.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>County Baltimore Co MD</b>          |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Heritage Nursing Home</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>-</b>                                  |  |
| 13a. STATE<br><b>md.</b>   |   | 13b. COUNTY<br><b>Baltimore</b>   | 13c. INSIDE CITY LIMITS?<br><b>YES</b>   | 13d. STREET ADDRESS<br><b>2506 Hillcrest Ave.</b>                              |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James E Wirtz</b>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Elizabeth Horning</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>213-07-6891</b>  |  | 17. INFORMANT<br><b>Beverly Hannan RN / Heritage Nsg. Home</b>                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ACUTE RESPIRATORY FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>METASTATIC CA. (stage IV Lymphoma)</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>-</b> |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2028</b><br><b>2092</b><br><b>months</b>                                |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>-</b>  |   |   |  |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/31</b> , 19 <b>82</b> , to <b>4/12</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>4/12</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                       |   |   |  |  |  |
| 22b. SIGNATURE<br><b>B. C. VENERACION JR MD</b>  |   |   |  | 22c. DATE SIGNED<br><b>4/12</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>B. C. VENERACION JR MD</b>   |   |   |  | 22e. ADDRESS<br><b>3401 DUNDALK AVE 21222</b>                                  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |   | 23b. DATE<br><b>4/15/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer</b>                     |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 14 1982</b>   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J Ruck Inc. Baltimore, Maryland</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles J. Nathan</b>  |  |  |  |

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APR 14 1983

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |                     |  | 8 2 0 8 7 0 2<br>REG. NO.                    |     |        |           |
|---|--|---|--|---|--|---|--|---------------------|--|--|-----|--------|-----------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST   |  | MIDDLE  |  | LAST  |  | 2a. DATE OF DEATH   |  | MONTH  | DAY | YEAR   | 2b. HOUR  |
| Frances (Filemena) G. Kotschenreuther   |  |   |  |   |  |   |  | April 9 1982        |  |  |     |        | 9:58 A.M. |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE  |  | 7. IF UNDER 1 YEAR  |  | 8. IF UNDER 24 HRS.                          |     |        |           |
| Female  |  | White   |  | Dec. 31, 1903   |  | 78  |  | YRS.                |  | MONTHS                                       |     | DAYS   |           |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                     |  |  |     |        |           |
| Ohio  |  | USA   |  |   |  | Baltimore County  |  |                     |  |  |     | MD.    |           |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                     |  |  |     |        |           |
| Towson  |  | St. Joseph Hospital   |  | Housewife   |  |   |  |                     |  |  |     |        |           |
| 13a. STATE  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS |  |  |     |        |           |
| Md.   |  |   |  | Baltimore   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 2301 Pentland Drive |  |  |     |        |           |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME  |  |   |  |   |  |                     |  |  |     |        |           |
| Michael   |  | Policchiastr  |  | Antonia   |  | Nunziata  |  |                     |  |  |     |        |           |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT   |  | ADDRESS   |  |                     |  |  |     |        |           |
| no  |  | 216-24-4615   |  | Mr. James A. Kotschenreuther  |  | 1606 Taylor Ave   |  |                     |  |  |     |        |           |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Weak myocardial infarction</u><br><u>4100</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <u>Arteriosclerotic vascular disease.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |  |   |  |   |  |                     |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |     |        |           |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)<br><u>Diabetes mellitus</u>  |  |   |  |   |  |   |  |                     |  |  |     |        |           |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |                     |  |  |     |        |           |
|   |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |                     |  |  |     |        |           |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |                     |  |  |     |        |           |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |                     |  |  |     |        |           |
| 22a. I certify that (X) (this hospital) attended the deceased from April 1, 19 82, to April 9, 19 82, that (X) (we) lost saw the deceased alive on April 9, 19 82, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |  |                     |  |  |     |        |           |
| 22b. SIGNATURE  |  | DEGREE  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED  |  |                     |  |  |     |        |           |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS  |  |   |  |   |  |                     |  |  |     |        |           |
| E. NAKARIMA M.D.  |  | 2300 Pulaski Valley Rd  |  |   |  |   |  |                     |  |  |     | 21204. |           |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |  |                     |  |  |     |        |           |
| Burial  |  | April 13, 1982  |  | Sacred Heart of Jesus Dundalk Balto.  |  | Md.   |  |                     |  |  |     |        |           |
| 24. FUNERAL DIRECTOR<br>NAME  |  | ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR   |  | REGISTRAR'S SIGNATURE   |  |                     |  |  |     |        |           |
| Leonard J. Ruck Inc. Baltimore, Maryland  |  |   |  | APR 12 1982   |  | Name J. J. J. J.  |  |                     |  |  |     |        |           |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |  |                             |  |   | 8 2 0 8 / 0 3<br>REG. NO.  |   |  |  |
|--|--|---|--|---|--|--|-----------------------------|--|---|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>MARIE E. KRATZ   |  |   |  |   | 2a. DATE OF DEATH<br>April 10, 1982                            |  |                             |  | 2b. HOUR<br>M   |  |   |  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>July 26, 1896   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>85 YRS                                      |                             | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |   | IF UNDER 24 HRS  |   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                   |                             |  |   |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Towson  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1667 Thetford Road |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Home Maker |                             | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home  |   |  |   |  |  |
| 13a. STATE<br>Maryland   |  |   |  |   | 13b. COUNTY<br>Baltimore                                       |  | 13c. CITY OR TOWN<br>Towson |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>1667 Thetford Road |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>UNKNOWN Berger   |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Barbara Ermer |  |                             |  |   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>218-52-4944D   |  | 17. INFORMANT<br>ADDRESS<br>M. Anne Laubach Same as #13.  |  |  |                             |  |   |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Hypertensive Cardiovascular Disease</u><br><u>4029</u> DUE TO, OR AS A CONSEQUENCE OF <u>with Congestive Heart Failure (Terminal)</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |  |   |  |  |                             |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>20 years   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Diabetes Mellitus</u>  |  |   |  |   |  |  |                             |  |   |  |   |  |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |                             | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2) |                             |  |   |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                             |  |   |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>April 6</u> , 19 <u>82</u> , to <u>April 10</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>April 6</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.   |  |   |  |   |  |  |                             |  |   |  |   |  |  |
| 22b. SIGNATURE<br><u>Robert W. Garis, M.D.</u> DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  |   |  |   |  |  |                             | 22c. DATE SIGNED<br>4/11/82  |   |  |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Robert W. Garis, M.D.   |  |   |  |   |  | 22e. ADDRESS<br>3811 Canterbury Road   |                             |  |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>April 14, 1982   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Woodlawn Cemetery   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Woodlawn Baltimore Maryland      |                             |  |   |  |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Ruck Towson Funeral Home, Inc. Towson, Maryland  |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>APR 12 1982                                   |                             |  |   |  |   |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/B1  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |  |   |  |  |  |
|--|--|---|--|--|--|---|--|--|--|
| 1 - FOR STATE REGISTRAR<br><b>JOHN G. KREINER</b>  |  |   |  |  |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>John F. Kreiner</b>  |  |   |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4 - 24 - 82</b>                                       |  | 2b. HOUR<br><b>10 45 P M</b>   |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 14 '00</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b>  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>YRS</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>      |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY MD.</b>                             |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>ROSSVILLE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>MANOR CARE Nursing Home</b> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SUPERVISOR</b>           |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>BETH. STEEL</b>  |  |
| 13a. STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>BALTIMORE</b>   |  | 13c. CITY OR TOWN<br><b>ROSEDALE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>1813 WOODRUFF AVE.</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>GEORGE KREINER</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ANNA</b>   |  |   |  | 16. ADDRESS<br><b>1813 WOODRUFF AVE.</b>   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>213079219</b>  |  | 17. INFORMANT<br><b>FANNIE KREINER</b>   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myelofibrosis with Myelogenous Leukemia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 yrs.</b> |  |   |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>Arteriosclerotic Heart disease</b>  |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>4/12/82</b> to <b>4/24/82</b> that (I) (we) last saw the deceased alive on <b>4/24/82</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>John F. Kreiner</b>   |  |   |  | DEGREE<br><b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   |  | 22c. DATE SIGNED<br><b>4/25/82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>KHIN -M. TUN.</b>  |  |   |  | 22e. ADDRESS<br><b>2110 Pot Spring Road Md 21093.</b>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>4/27/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>OAKLAWN CEMETERY</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO BALTIMORE MD</b>                         |  | 23e. DATE REC'D. BY REGISTRAR<br><b>APR 26 1982</b>  |  |
| 24. FUNERAL DIRECTOR<br><b>John F. Kreiner</b> ADDRESS<br><b>1211 Chesapeake Ave.</b>  |  |   |  |  |  |   |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DHMH - 16 50M 1/81  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |   |   |   |  |  | 8 2 0 8 7 0 5<br>REG. NO.  |  |
|--|--|--|--|---|---|---|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Myrtle Esther Keetzler</b>  |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>04 20 82</b>                  |   |   | 2b. HOUR<br><b>7<sup>18</sup> P.M.</b>   |  |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Caucasian</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Nov. 11, 1903</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b>  |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County, MD.</b>                            |   |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NO IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Batts Co. Gen. Hospital</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Assembly Line Wk</b>     |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Manufacturing</b>                          |  |  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Woodlawn</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>7902 Dogwood Road</b>                                    |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Randolph Twigg</b>  |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Margaret Keefer</b> |   |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>N/A</b>  |  | 17. INFORMANT<br><b>Goldie Oakman, 7902 Dogwood Road</b>  |   | ADDRESS   |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Arterio MT</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)             |  |  |  |   |   |   |   |  |  | APPROPRIATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Immediate</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b)  |  |  |  |   |   |   |   |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   |   | 20a. ALLTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTES MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>JAN 24</b> 19 <b>77</b> to <b>MAR 13</b> 19 <b>82</b> that (I) (we) last saw the deceased alive on <b>MAR 13</b> 19 <b>82</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |   |   |   |   |  |  |  |  |
| 22b. SIGNATURE<br><b>Howard J. Garber</b>  |  |  |  |   |   | DEGREE<br><b>ATTENDING PHYSICIAN</b>  |   | MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>4-21-82</b>                               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Howard J. Garber</b>   |  |  |  |   |   | 22e. ADDRESS<br><b>5310 Old Court Rd.</b>   |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>4/24/82</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn Cemetery</b>          |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Woodlawn, Baltimore Co., Md.</b> |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Frank J. Dell Kree</b>  |  |  | WOODLAWN MEMORIAL FH.<br><b>6111 Windsor Mill Rd.</b>                  |   |   | 25a. DATE REC'D BY REGISTRAR<br><b>APR 26 1982</b>  |   | 25b. SIGNATURE<br><b>Frank J. Dell Kree</b>  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTER

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 / 0 6  
REG. NO.

|  |  |   |  |   |  |  |   |  |
|--|--|---|--|---|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Theresa Kristian</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>04 12 82</b> |   | 2b. HOUR<br><b>9:04 AM</b>   |  |   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>07 20 87</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>94</b> YRS.  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Austria</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Overlea</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>4709 Forest View Ave. 21206</b> |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Homemaking</b>  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE 13b. COUNTY 13c. CITY OR TOWN 13d. INSIDE CITY LIMITS? 13e. STREET ADDRESS<br><b>Maryland Baltimore Overlea YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 4709 Forest View Avenue</b>   |  |   |  |   |  |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Hruska</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Anna Straka</b>   |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>179-10-2160D</b>  |  | 17. INFORMANT ADDRESS<br><b>Donald Kristian 4709 Forest View Ave</b>  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Renal Failure</b><br><b>4289</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Cardia failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Respiratory failure</b>                  |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 week</b><br><b>1 week</b><br><b>1 week</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>N/A</b>  |  |   |  |   |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/14/82</b> 19 <b>82</b> , to <b>4/12</b> 19 <b>82</b> , that (I) (we) lost above (I) (we) (did) (did not) view the body after death. <b>3/14/82</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated |  |   |  |   |  |  |   |  |
| 22b. SIGNATURE<br><b>Gary Roggin</b>   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>4/13/82</b>   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Gary Roggin, M.D.</b>  |  |   |  | 22e. ADDRESS<br><b>9660 Belair Road</b>   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>4/16/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Peter &amp; Paul</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Hazelton Luzerne Pa.</b>  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Lassahn Funeral Home</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 15 1982</b>   |  |  |   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |   |  |   |  |  |   |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 7 0 7

REG. NO.

|  |   |   |   |   |  |
|--|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>DOROTHY M KUHLMAN  |   | 2a. DATE OF DEATH<br>4-24-82<br>4-24-82   |   | 2b. HOUR<br>456pm   |  |
| 3. SEX<br>Female   | 4. RACE<br>White  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Aug. 25 1895  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>86 YRS   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD                                     |  |
| 10. CITY OR TOWN OF DEATH<br>TOWSON MD   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ST JOSEPH HOSPITAL |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY<br>-  |  |
| 13a. STATE<br>Md.  |   | 13b. COUNTY<br>Baltimore  | 13c. CITY OR TOWN<br>Baltimore  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>5128 McFaul Rd.   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Lang  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Gertrude Vogel   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no   |   | 16b. SOCIAL SECURITY NO.<br>213-52-2994   | 17. INFORMANT ADDRESS<br>Jerome Kuhlman (son) same address                    |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u><br>4275<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |   |   |   |   |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (this hospital) attended the deceased from 4/22, 19 82, to 4/24, 19 82, that (we) lost<br>saw the deceased alive on 4/24, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (we) (did) (did not) view the body after death.   |   |   |   |   |  |
| 22b. SIGNATURE<br>G D Harvey<br>GREGORY HARVEY M D   |   | DEGREE<br>MD  |   | 22c. DATE SIGNED<br>4/24/82   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>GREGORY HARVEY  |   | 22e. ADDRESS<br>5128 McFaul Rd<br>ST JOSEPH'S HOSP  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |   | 23b. DATE<br>4/27/82  | 23c. NAME OF CEMETERY OR CREMATORY<br>Holy Redeemer                           |   | 23d. LOCATION<br>CITY OR TOWN COUNTY<br>Baltimore  |
| 24. FUNERAL DIRECTOR<br>Schimunek Funeral Home, Inc.<br>3331 Brehms Lane, Balto. Md. 21213   |   |   | 25a. DATE REC'D. BY REGISTRAR<br>APR 27 1982                                  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST   |  | MIDDLE  |  | LAST  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR   |  | 2b. HOUR  |  |
| JOHN   |  | R   |  | LABONTE   |  |   |  | 4-28-82   |  | 4:50p M   |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS.<br>HOURS MIN.                  |  |
| Male   |  | White   |  | Feb. 18, 1911   |  | 71 YRS  |  |   |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |   |  |   |  |
| Maryland   |  | USA   |  |   |  | BALTIMORE COUNTY  |  |   |  | MD.   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |  |   |  |
| TOWSON   |  | ST. JOSEPH HOSPITAL   |  | Steel Fabricator  |  | Steel   |  |   |  |   |  |
| 13a. STATE   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS   |  |   |  |
| Maryland   |  |   |  | Baltimore   |  |   |  | 1217 Gleneagle Rd.  |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |  |   |  |   |  |   |  |
| Harry Daniel LaBonte, Sr.  |  |   |  | Dorothy Margaret Hiob   |  |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | (IF YES, GIVE WAR OR DATES)   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT   |  | ADDRESS   |  |   |  |
| No   |  |   |  | 213-10-1751   |  | Edith Dorsey LaBonte  |  | Same  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA, LUNGS, BILATERAL</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>CARCINOMA OF THE PANCREAS WITH</u><br>DUE TO, OR AS A CONSEQUENCE OF <u>DISSEMINATED METASTASES</u><br>(c) _____   |  |   |  |   |  |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____   |  |   |  |   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 4-28-82 to 4-28-82, that <input checked="" type="checkbox"/> (we) lost<br>saw the deceased alive on 4-28-82, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated<br>above, <input checked="" type="checkbox"/> (we) (did) not view the body after death. |  | 22b. SIGNATURE<br><i>M B Furlong Jr MD</i>  |  | DEGREE  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS  |  |   |  |   |  |   |  |   |  |
| M B FURLONG JR MD  |  | 7620 YORK ROAD TOWSON MD  |  |   |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |   |  |   |  |
| Burial   |  | May 3, 1982   |  | Meadowridge   |  | Elkridge, Balto. Co., Md.   |  |   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |   |  |   |  |   |  |
| Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212  |  | 6500 York Rd.   |  | MAY 5 1982  |  |   |  |   |  |   |  |

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White 10, 1911  
USA  
Steel Fabricator  
1217 Clancy St. N.

1217 Clancy St. N.  
1217 Clancy St. N.  
1217 Clancy St. N.



BRONCHITIS, LUNGS, BILABIAL  
BRONCHITIS, LUNGS, BILABIAL  
BRONCHITIS, LUNGS, BILABIAL

M 8

1217 Clancy St. N.  
1217 Clancy St. N.  
1217 Clancy St. N.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 2 0 8 7 0 9  
REG. NO.

|   |  |  |   |   |                            |  |  |
|---|--|--|---|---|----------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>MARIE A LACEY</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4-26-82</b> |   | 2b. HOUR<br><b>11:51am</b> |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>March 5, 1897</b>  |                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>85</b><br>YRS. MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST JOSEPH HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired Secretary &amp; Mskpr</b>  |                            | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |                            | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Thomas Lacey</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE<br><b>Clara Drayer</b>  |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |                            | 16b. SOCIAL SECURITY NO.<br><b>216-05-3692</b>   |  |
| 17. INFORMANT<br><b>Mrs Alice Livingston</b>  |  | ADDRESS<br><b>Same</b>   |   | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>4100 IMMEDIATE CAUSE (a) CARDIAC TAMPONADE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>RUPTURE OF INFARCTED MYOCARDIUM</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) |                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.<br><b>MYOCARDIAL INFARCTION DUE TO ARTERIOSCLEROTIC CORONARY ARTERY DISEASE</b>   |  |  |   |   |                            |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |                            |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                            |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>4-18</b> , 19 <b>82</b> , to <b>4-26</b> , 19 <b>82</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>4-26</b> , 19 <b>82</b> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. (did <input checked="" type="checkbox"/> view the body after death.) |  |  |   |   |                            |  |  |
| 22b. SIGNATURE<br><br>DEGREE<br><b>M.D.</b>  |  |  |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |                            | 22c. DATE SIGNED<br><b>4-27-82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>REYNALDO ORJUELA-GOMEZ, M.D.</b>  |  |  |   | 22e. ADDRESS<br><b>7620 YORK ROAD TOWSON MD 21204</b>   |                            |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>4/30/82</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral</b>  |                            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J Ruck Inc. Baltimore, Maryland</b>  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 28 1982</b>   |                            | 25b. REGISTRAR'S SIGNATURE<br>        |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director. Page 4 should be retained by the funeral director. Page 5 should be retained by the funeral director. Page 6 should be retained by the funeral director. Page 7 should be retained by the funeral director. Page 8 should be retained by the funeral director. Page 9 should be retained by the funeral director. Page 10 should be retained by the funeral director. Page 11 should be retained by the funeral director. Page 12 should be retained by the funeral director. Page 13 should be retained by the funeral director. Page 14 should be retained by the funeral director. Page 15 should be retained by the funeral director. Page 16 should be retained by the funeral director. 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Page 93 should be retained by the funeral director. Page 94 should be retained by the funeral director. Page 95 should be retained by the funeral director. Page 96 should be retained by the funeral director. Page 97 should be retained by the funeral director. Page 98 should be retained by the funeral director. Page 99 should be retained by the funeral director. Page 100 should be retained by the funeral director.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 82 08710

|  |   |   |  |   |  |
|--|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>William S. Langford</b>   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 25, 1982</b>  |  | 2b. HOUR<br>MIN.<br><b>11:25a</b>   |  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Aug. 3, 1905</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><b>76</b>                                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                             |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Joseph Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Self Employed</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Dry Cleaning</b> |
| 13a. STATE<br><b>Maryland</b>  |   | 13b. COUNTY<br><b>Baltimore</b>   | 13c. CITY OR TOWN<br><b>Baltimore</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>1912 Woodbourne Ave.</b>       |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William E. Langford</b>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Rosie Brittain</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>214-03-1652</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Elizabeth M. Langford 1912 Woodbourne Ave.</b>                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Staphylococcal Pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Generalized Paralysis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Diffuse Atherosclerosis</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                     |   |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>Cerebral Atrophy, Cerebral Atherosclerosis, Parkinson's Disease, Cystic Kidney, Azotemia</b>  |   |   |  |   |  |
| 19a. DATE OF OPERATION<br><b>N/A</b>   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>N/A</b>  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH<br>(IF EITHER, GIVE MEDICAL EXAMINER'S NAME)<br><b>N/A</b>   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>N/A</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>N/A</b>    |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FARM, OTHER, TRAIN, ETC.)<br><b>N/A</b>   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>N/A</b>                                 |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>April 19, 1982</b> , to <b>April 25, 1982</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>April 25, 1982</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) and <input type="checkbox"/> (we) view the body after death. |   |   |  |   |  |
| 22b. SIGNATURE<br><b>Alfred H. Tanoski</b>   |   | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>4/25/82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Alfred H. Tanoski</b>  |   | 22e. ADDRESS<br><b>7620 York Rd., Towson, MD 21204</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |   | 23b. DATE<br><b>Apr. 29, 1982</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardens of Faith</b>                                   |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>  |   | 23e. DATE OF REGISTRATION<br><b>APR 27 1982</b>   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Leonard J. Ruck, Inc. Baltimore, Maryland</b>   |   | 25. REGISTRAR'S SIGNATURE<br><b>James Santhorn</b>  |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 8 2 0 8 7 1 1   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  | REG. NO.  |  |  |  |
| DECEASED NAME (TYPE OR PRINT)<br>THERESA LAZOFF  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>APRIL 4, 1982   |  |  |  |
| 2b. HOUR<br>9:15 AM  |  |   |  |   |  |  |  |
| 3. SEX<br>FEMALE   |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>JUNE 2, 1907   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>74 YRS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD                          |  |
| 10. CITY OR TOWN OF DEATH<br>PIKESVILLE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>25 WARREN PARK DR. APT. B-3 |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>HOME  |  |
| 13a. STATE<br>MARYLAND   |  |   |  | 13b. COUNTY<br>BALTIMORE  |  | 13c. CITY OR TOWN<br>PIKESVILLE  |  |
| 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |  | 13e. STREET ADDRESS (21208)<br>25 WARREN PARK DR. APT. B-3  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>ABRAHAM MYERS   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>CELE UNKNOWN  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO  |  |   |  | 16b. SOCIAL SECURITY NO.<br>219-70-6192   |  | 17. INFORMANT ADDRESS (21208)<br>MAURICE LAZOFF 25 WARREN PARK DR. APT. B-3          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIO-PULMONARY ARREST</u><br>4148<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>MYOCARDIAL ISCHEMIA</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)<br><u>HYPERTENSION</u>  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>MAR 30</u> 19 <u>81</u> to <u>MAR 30</u> 19 <u>82</u> , that (I) (we) lost the deceased alive on <u>MAR 30</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Ramon S. Pimentel</u>   |  |   |  | DEGREE<br>M.D.  |  | 22c. DATE SIGNED<br>4-5-82   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>RAMON PIMENTEL  |  |   |  | 22e. ADDRESS<br>7501 LIBERTY RD. (21135) 21207  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  | 23b. DATE<br>4-5-82   |  | 23c. NAME OF CEMETERY<br>BETH HAMEDROSH HAGODOL   |  | 23d. LOCATION CITY OR TOWN<br>ROSEDALE, BALTO.                                       |  |
| 24. FUNERAL DIRECTOR<br>SOL LEVINSON & BROS.<br>6010 REISTERSTOWN RD. BALTIMORE, MD. (21215)   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>APR 8 1982   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Ramon S. Pimentel</u>                               |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 7 1 2

REG. NO.

|  |   |   |  |  |  |   |
|--|---|---|--|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>SOPHIA LEADER</b>   |   |   | 2a. DATE OF DEATH<br><b>APRIL 4, 1982</b>  |  | 2b. HOUR<br><b>7:45 AM</b>                       |   |
| 3. SEX<br><b>FEMALE</b>  | 4. RACE<br><b>WHITE</b>   | 5. DATE OF BIRTH<br><b>AUG. 2, 1914</b> YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b>   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.        |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.  |  |   |
| 10. CITY OR TOWN OF DEATH<br><b>PIKESVILLE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3318 KEYSER RD. (21208)</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>HOME</b> |   |
| 13a. STATE<br><b>MARYLAND</b>  |   | 13b. COUNTY<br><b>BALTIMORE</b>   | 13c. CITY OR TOWN<br><b>PIKESVILLE</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |
| 14. FATHER'S NAME<br>FIRST <b>IRVIN</b> MIDDLE <b>AARON</b> LAST <b>LEVINSON</b>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>IDA</b> MIDDLE <b>POLSWOLSKY</b>   |  |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>214-18-9591</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>MRS. HELENE SKLAR 3318 KEYSER RD. (21208)</b>   |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>METASTATIC CARCINOMA</b><br><b>1749</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CARCINOMA OF BREAST</b><br>6 yrs<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |   |   |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>one year</b>  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>NO</b>   |   |   |  |  |  |   |
| 19a. DATE OF OPERATION<br><b>—</b>   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>—</b>  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>— P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>—</b>   |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>—</b>  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>—</b>  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1 DEC 81</b> 19 <b>81</b> , to <b>4 APR</b> 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>1 APR 82</b> , and that it (my) (our) opinion death occurred on the date and hour and from the causes stated    |   |   |  |  |  |   |
| 22b. SIGNATURE<br><b>Malcolm Druskin</b>   |   | DEGREE<br><b>—</b>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>4/5/82</b>   |
| 22d. PHYSICIAN'S NAME<br><b>MALCOLM DRUSKIN, M.D.</b><br><b>STEPHEN GLASSER</b>  |   | 22e. ADDRESS<br><b>600 REISTERSTOWN RD. BALTIMORE, MD. (21208)</b>  |  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |   | 23b. DATE<br><b>4-5-82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ARLINGTON CEM</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE, MD.</b>   |
| 24. FUNERAL DIRECTOR'S NAME<br><b>SOL LEVINSON &amp; BROS.</b><br><b>6010 REISTERSTOWN RD. BALTIMORE, MD. (21215)</b>  |   |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 8 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Thane Jan Martin</b>   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

541

1 - FOR  
STATE  
REGISTRAR

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8

REG. NO.

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|---|---|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>ORVILLE FRANCIS LEITER</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>APRIL 19, 1982</b>                          |   | 2b. HOUR<br><b>9:35 A.M.</b>  |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>WHITE</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>SEPTEMBER 8, 1916</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>65</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>COLORADO</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.                             |   |
| 10. CITY OR TOWN OF DEATH<br><b>FORT HOWARD</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>VA MEDICAL CENTER</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Production</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Bleach &amp; Dye</b>  |
| 13a. STATE<br><b>MARYLAND</b>   |   | 13b. COUNTY   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ED LEITER</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>JOAN PALMER</b>   |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>505 01 0567</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>CLINICAL RECORDS, VAMC, FORT HOWARD, MD</b>                      |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ASPIRATION PNEUMONIA, LEFT</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>ORGANIC BRAIN SYNDROME</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>FRACTURE OF LEFT HIP</b>  |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>14 DAYS</b><br><b>YEARS</b><br><b>4 MONTHS</b>                                     |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |   |   |   |   |   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>DECEMBER 16</b> 19 <b>81</b> to <b>APRIL 19</b> 19 <b>82</b> , that <input checked="" type="checkbox"/> (I) (we) last saw the deceased alive on <b>APRIL 19</b> 19 <b>82</b> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |   |   |   |   |
| 22b. SIGNATURE<br><i>Wen Shyang Wu</i>  |   |   |   | 22c. DATE SIGNED  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>WEN-SHYANG WU, M.D.</b>   |   |   |   | 22e. ADDRESS<br><b>VA MEDICAL CENTER, FORT HOWARD, MD 21052</b>                                 |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |   | 23b. DATE<br><b>4/21/82</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine Park Cem.</b>                                 |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Woodlawn Balto. Co. Md.</b>  |   | 23e. DATE REC'D. BY REGISTRAR (BY REGISTRAR'S SIGNATURE)<br><b>APR 21 1982</b>  |   |   |   |
| 24. FUNERAL DIRECTOR<br>ADDRESS<br><b>Burgee Funeral Home 3631 Falls Road 21211</b>   |   |   |   |   |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |  |  | REG. NO. 8 2 0 8 7 1 4                       |  |          |  |
|--|--|--|--|---|--|---|--|--|--|--|--|----------|--|
| 1. FOR STATE REGISTRAR   |  |  |  |   |  |   |  |  |  | 2a. DATE OF DEATH                            |  | 2b. HOUR |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>LEE H. LEVELY  |  |  |  |   |  |   |  |  |  | 4 7 82                                       |  | 7:55 AM  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11 12 71  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>90 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.               |  |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>COUNTY BALTO MD.  |  |  |  |  |  |          |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Multi-Medical Nursing cntr, |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired                     |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>--  |  |  |  |          |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>--  |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>3107 Huntington Ave. (21211)  |  |  |  |          |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Tuck Levely  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Lee   |  |   |  |  |  |  |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>--  |  | 17. INFORMANT<br>ADDRESS<br>215-09-4650   |  | Maryenis Lindsay-3107 Huntinton Ave. 21211  |  |  |  |  |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Metastatic Colon Cancer</u><br>1539<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c)<br>DUE TO, OR AS A CONSEQUENCE OF<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) |  |  |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |          |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |  |  |  |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |  |  |          |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |  |  |          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 81 to 4 7 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |  |  |  |  |  |          |  |
| 22b. SIGNATURE<br>Alan S. Grofsky  |  |  |  | DEGREE<br>MD  |  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>4/7/82                   |  |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ALAN S. GROFSKY   |  |  |  | 22e. ADDRESS<br>1708 WHITEHEAD RD, BALTIMORE 21207  |  |   |  |  |  |  |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>4/10/82   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore Cemetery  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland                               |  |  |  |  |  |          |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>A. Alan Seitz Funeral Home   |  |  |  | ADDRESS<br>3818 Roland Ave.   |  | 25a. DATE REC'D. BY REGISTRAR<br>APR 12 1982  |  | 25b. REGISTRAR'S SIGNATURE<br>Rene J. [Signature]  |  |  |  |          |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |   |   |  |   |  |
|--|--|--|--|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>WILLIAM A. LEVISON  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>4-22-82           |   |   | 2b. HOUR<br>6:42 PM  |   |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH<br>APR. 22, 1888   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>94  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>RUSSIA  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.   |   |  |
| 10. CITY OR TOWN OF DEATH<br>RANDALLSTOWN  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>BALTIMORE COUNTY GEN. HOSP. |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>AGENT   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>INSURANCE   |   |  |
| 13a. STATE<br>MARYLAND   |  |  | 13b. COUNTY<br>BALTO.                                    |   | 13c. CITY OR TOWN<br>BALTIMORE  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>UNKNOWN  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>UNKNOWN |   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  |  | 16b. SOCIAL SECURITY NO.<br>215-05-9713A                 |   | 17. INFORMANT<br>MR. HERBERT E. LEVISON<br>409 PARK AVE. BALTO., MD 21201 |  |   |  |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CERE BRO - VASCULAR ACCIDENT<br>4360<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |   |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:<br>CONGESTIVE HEART FAILURE  |  |  |  |   |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-1, 19 82, to 4-22, 19 82, that (I) (we) last saw the deceased alive on 4-22, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |   |  |   |  |
| 22b. SIGNATURE<br>Orlando B. Conanan   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |   | 22c. DATE SIGNED<br>4-22-82  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ORLANDO B. CONANAN, MD.   |  |  |  | 22e. ADDRESS<br>BCGH - RANDALLSTOWN MD. 21133   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) BURIAL  |  | 23b. DATE<br>APR. 26, 1982   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>HAR ZION TIFERETH ISRAEL  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>ROSEDALE BALTO. MD   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME SOL LEVINSON & BROS., INC.<br>ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>APR 28 1982  |   |  |   |  |
|  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br>James J. Nathan   |   |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with your office after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 7 1 6

REG. NO.

|  |  |   |   |   |  |  |   |  |  |  |
|--|--|---|---|---|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>JACK I. LEVY  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>4-8-82                         |   |  | 2b. HOUR<br>2:40 P.M.  |   |  |  |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>WHITE  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>FEB. 20, 1920   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>62 YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>NEW YORK  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.   |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>RANDALLSTOWN  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>BALTIMORE COUNTY GENERAL HOSP. |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>POLICEMAN  |   | 12b. BUSINESS OR INDUSTRY<br>BALTO. POLICE DEPT.   |  |  |
| 13a. STATE<br>MARYLAND   |  |   | 13b. COUNTY<br>BALTO.   |   | 13c. CITY OR TOWN<br>BALTIMORE   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>7113 MANILA AVE. #21207 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>LOUIS LEVY   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>GUSSIE HAUSER        |   |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>YES  |  |   | 16b. SOCIAL SECURITY NO.<br>WWII-ARMY 105-12-2115                     |   | 17. INFORMANT<br>MRS. MILDRED LEVY<br>7113 MANILA AVE. BALTO., MD              |  | 21207   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIOGENIC SHOCK</u><br>4148<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>OLD MYOCARDIAL INFARCTION</u> |  |   |   |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><u>DIABETES MELLITUS; LIVER FAILURE</u>  |  |   |   |   |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                      |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19            |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4-2</u> , 19 <u>82</u> , to <u>4-8</u> , 19 <u>82</u> . That (I) (we) lost saw the deceased alive on <u>4-8</u> , 19 <u>82</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |   |  |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Orlando B. Conanan, M.D.</u>  |  |   | DEGREE  |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |  | 22c. DATE SIGNED<br>4-8-82                     |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ORLANDO B. CONANAN, M.D.  |  |   | 22e. ADDRESS<br>BCGH - RANDALLSTOWN MD. 21133                         |   |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  |   | 23b. DATE<br>APR. 11, 1982  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>MOSES MONTEFIORE                         |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE MARYLAND                                |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME SOL LEVINSON & BROS., INC.<br>ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215  |  |   |   |   |  | 25a. DATE REC'D. BY REGISTRAR<br>APR 15 1982   |   |  |  |  |

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U.S. DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D.C.

*[Faint, illegible text, likely bleed-through from the reverse side of the page]*

APR 15 1900

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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|  |  |   |   |   |   |
|--|--|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>THOMAS HICKMAN LONG   |  | 2a. DATE OF DEATH<br>4-16-82  |   | 2b. HOUR<br>unknown   |   |
| 3 SEX<br>M   | 4 RACE<br>CAUCASIAN  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>APRIL 16 1924   |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br>58 YRS.   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>TENNESSEE   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CO MD.  |   |
| 10. CITY OR TOWN OF DEATH<br>WOODLAWN  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>6309 MONIKA PLACE |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>CARPENTRY |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>CONSTRUCTION |
| 13a. STATE<br>MD   |  | 13b. COUNTY<br>BALTIMORE  | 13c. CITY OR TOWN<br>WOODLAWN   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br>6309 MONIKA PLACE          |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>BERTAL LONG  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>CORDIE CARTER  |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>YES 2  |  | 16b. SOCIAL SECURITY NO.<br>414-28-6311   |   | 17. INFORMANT<br>W.D. WENNERSTEN  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>sudden death</u><br>4130<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Cardiovascular disease, Angina</u><br>(c) <u>Hypertension</u>                                 |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>no</u>   |  |   |   |   |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |   |   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>April 5</u> 19 <u>82</u> to <u>April 10</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>April 10th</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) saw the body after death. |  |   |   |   |   |
| 22b. SIGNATURE<br>David Wilson MD  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                   |   | 22c. DATE SIGNED  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DAVID WILSON, M.D.  |  | 22e. ADDRESS<br>Loch Raven VA Hospital Baltimore Md.  |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>4-20-82  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>LAKEVIEW MEM. PARK, S. JEFFERSONVILLE, MD.                |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |   |   |   |   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Slack Funeral Home, Ellieville City Md. 21043  |  | 25a. DATE REC'D. BY REGISTRAR<br>APR 22 1982  |   | 25b. REGISTRAR'S SIGNATURE<br>Frances Jean Nathan   |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

118058

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 7 1 8

REG. NO.

|  |  |   |  |   |                      |   |  |  |  |  |  |
|--|--|---|--|---|----------------------|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>JOHN B. LOTZ, JR.  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>April 5, 1982 |   | 2b. HOUR<br>5:05 P M |   |  |  |  |  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>July 26, 1908   |                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br>73 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  | IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD                                     |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Towson  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>720 Camberley Circle |  |   |                      | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Public Relations            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Western   |  |  |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Towson   |                      | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>720 Camberley Circle #A4  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John B. Lotz   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Alvina Cortez  |                      |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>215 10 4145  |  | 17. INFORMANT<br>Mrs. John B. Lotz, Jr.,  |                      |   |  | ADDRESS<br>Same  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac arrest</u><br><u>4140</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Coronary sclerosis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |  |   |                      |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |                      |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                      |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |                      | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>Dec 65 Apt 5 82                            |  |  |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>8 Feb 82</u> to <u>Apr 5 82</u> that (I) (we) lost<br>saw the deceased alive on <u>8 Feb 82</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did not) view the body after death.   |  |   |  |   |                      |   |  |  |  |  |  |
| 22a. SIGNATURE<br><u>William G. Helfrich MD</u>  |  |   |  | DEGREE<br>MD  |                      |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22b. DATE SIGNED<br>4/6/82   |  |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. William G. Helfrich, M.D.   |  |   |  | 22e. ADDRESS<br>5006 Roland Ave., Balto., Md.   |                      |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |   |  | 23b. DATE<br>4/8/82   |                      | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto., Md.  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME Henry W. Jenkins & Sons Co.<br>ADDRESS 4905 York Road Balto., Md. 21212   |  |   |  |   |                      | 25a. DATE REC'D. BY REGISTRAR<br>APR 6 1982   |  | 25b. REGISTRAR'S SIGNATURE<br><u>James J. [Signature]</u>  |  |  |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 7 1 9

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Kevin C. Lowe, Sr.</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4 24 82</b>  |  | 2b. HOUR<br>M<br><b></b>   |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4 10 1935</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>47</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Edgemere</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>2218 Lodge Farm Road</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Dispatcher-Grief Brothers</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b></b>   |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   | 13c. CITY OR TOWN<br><b>Edgemere</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>              | 13e. STREET ADDRESS<br><b>2218 Lodge Farm Road</b>   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles A. Lowe, Sr.</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ordelle C. Clark</b>  |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b> |  |
| 17. SOCIAL SECURITY NO.<br><b>213-34-5070</b>   |  | 18. INFORMANT<br><b>Evelyn G. Lowe Balto., MD. 21219</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic transitional cell cancer of kidney to lungs.</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b></b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b></b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b></b>   |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>2/9/82</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b></b>   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                         | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)<br><b></b>                    |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b></b>   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b></b>   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>JAN-FEB 1982</b> to <b>present</b> , 19 <b></b> , that (I) (we) last saw the deceased alive on <b>Mid April 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Larry Waterbury, D.O.</b>  |  | DEGREE<br><b>D.O.</b>   |  | 22c. DATE SIGNED<br><b>4/26/82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Larry Waterbury</b>   |  | 22e. ADDRESS<br><b></b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  | 23b. DATE<br><b>4/28/1982</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holly Hill</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>White Marsh Maryland</b>                                    |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Duda-Ruck, Inc.</b>  |  | ADDRESS<br><b>7922 Wise Avenue Dundalk, MD. 21222</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 27 1982</b>  |  |
|   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles J. Kestner</b>   |  |  |  |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and an autopsy required.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

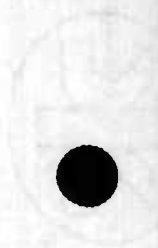
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be delivered for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 8 2 0 8 7 2 0   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>Eric C. Ludwig   |  |  |  | 2a. DATE OF DEATH<br>April 6, 1982  |  |  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>Jan. 4 1913   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>69  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Woodstock   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>10628 Davis Ave. Woodstock |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Truck Driver   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>REA Express   |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Baltimore   |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13d. STREET ADDRESS<br>4503 Furley Ave.  |  |
| 14. FATHER'S NAME<br>Otto  |  | 15. MOTHER'S MAIDEN NAME<br>Augusta  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>NO  |  |  |  |
| 16b. SOCIAL SECURITY NO.<br>217-07-7713  |  | 17. INFORMANT<br>Ronald E. Ludwig  |  | ADDRESS<br>10628 Davis Ave. Woodstock, Md.  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebro Pulmonary Arterial</u><br><u>1629</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cancer lung</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/</u> 19 <u>82</u> , to <u>4/</u> 19 <u>82</u> , that (I) (we) lost the deceased above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Mayo Thant</u>  |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                             |  | 22c. DATE SIGNED<br>4/7/82   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Mayo Thant, M.D.  |  | 22e. ADDRESS<br>Greater Baltimore Medical Center   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>4/10/82   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Parkwood  |  | 23d. LOCATION<br>Baltimore, Md.  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Leonard J. Ruck, Inc. Baltimore, Md.   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>APR 12 1982  |  | 25b. BY<br><u>James J. Thant</u>   |  |

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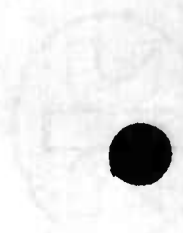
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |  |  | 8 2 0 8 7 2 1<br>REG. NO.   |  |  |  |
|---|--|--|--|---|--|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>LAURA JEAN LUKEN</b>   |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 12, 1982</b>                              |  |  |  | 2b. HOUR<br>MIN.<br><b>5:15a</b>  |  |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Aug 10, 1913</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS.<br><b>68</b>                                      |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b></b>  |  | IF UNDER 24 HRS.<br>HOURS MIN.<br><b></b>   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b>                           |  |  |  | MD.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Exx Rossville</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Square Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK, OCCUPATION, INDUSTRY)<br><b>Retired Secretary</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |  |  |  |   |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Rosdale</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George Stiemly</b>   |  |  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>MIDDLE LAST<br><b>Laura Pasquay</b>                           |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>215-07-6152</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Mr A. William Luken</b>  |  |   |  | Same   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiorespiratory Failure</b><br><b>1629</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>Small Cell Carcinoma of Lung</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b>   |  |  |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Probable Brain and Liver Metastasis</b>   |  |  |  |   |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |  |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET   |  | CITY OR TOWN  |  | COUNTY   |  | STATE   |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>March 7</b> , 19 <b>82</b> , to <b>April 12</b> , 19 <b>82</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>April 12</b> , 19 <b>82</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Patricia J. Middleton M.D.</b>   |  |  |  |   |  | DEGREE<br><b>M.D.</b>   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>4-12-82</b>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Patricia Middleton</b>  |  |  |  |   |  | 22e. ADDRESS<br><b>9000 Franklin Square Drive 21237</b>                                   |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>4/14/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>                  |  |  |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J Ruck Inc. Baltimore, Maryland</b>  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 13 1982</b>                                       |  | 25b. REGISTRAR'S SIGNATURE<br><b>James J. [Signature]</b>  |  |   |  |  |  |

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 7 2 2

REG. NO.

|  |  |  |   |   |  |   |  |  |  |
|--|--|--|---|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>John --- LUNTZ, Jr.   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>April 10, 1982   |   |  | 2b. HOUR<br>24, M   |  |  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>March 23, 1890  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>92 YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County, MD.                                   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Rodgers Forge   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>711 Walker Avenue |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Salesman  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Lumber/grain   |  |  |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Baltimore   |   | 13c. CITY OR TOWN<br>Rodgers Forge  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>711 Walker Avenue   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Luntz   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Miller |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>-----   |   | 17. INFORMANT<br>John G. Luntz  |  | ADDRESS<br>Fairfield, Penna.  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIO Respiratory Arrest</u><br><u>4292</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <u>ARTEROSCLEROTIC CARDIOVASCULAR Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>min</u><br><u>4 yrs</u> |  |  |   |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |   |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>JAN 3</u> 19 <u>71</u> , to <u>APRIL 10</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>MAR 20</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |   |   |  |   |  |  |  |
| 22b. SIGNATURE<br><u>S. J. Venable, Jr., M.D.</u>  |  |  |   | DEGREE<br>M.D.  |  |   |  | 22c. DATE SIGNED<br>4-10-82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>S. J. Venable, Jr., M.D.  |  |  |   | 22e. ADDRESS<br>610 Wilton Road Baltimore, Maryland   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>Apr. 14, 82   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Druid Ridge Cemetery  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Co., Md.                                |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Dippel Funeral Homes, Inc.   |  |  |   | ADDRESS<br>Baltimore, Md.   |  | 25a. DATE REC'D. BY REGISTRAR<br>APR 13 1982  |  | 25b. REGISTRAR'S SIGNATURE<br><u>James J. Nathan</u>   |  |

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 8 2 0 8 7 2 3  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1 - STATE REGISTRAR  |  |   |  | REG. NO.   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>IRENE M LYONS</b>   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>April 13, 1982</b>  |  | 2b. HOUR<br><b>9:55 PM</b>  |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>CAUCASIAN</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>1 4 1991</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN.<br><b>90</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE County MD</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST JOSEPH HOSPITAL</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Sales - Arundel</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Ice Cream Store</b>   |  |
| 13a. STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>BALTIMORE</b>   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>James Walter Langley</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Amizora Walker</b>   |  | 13e. STREET ADDRESS<br><b>725 Seneca Gardens Rd</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>215-12-7647A</b>   |  | 17. INFORMANT ADDRESS<br><b>Mr. Earl H. Wilkins 725 Seneca Gardens Road</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hypotension, (Shock)</b><br>4860<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Pneumonia, septicemia</b><br>(c) <b>6-8 hr</b>                    |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2-3 hr</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>Diabetes Mellitus Hypertension Coma</b>   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION<br><b>None</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>None</b>   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><b>None</b>  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.<br><b>None</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)<br><b>N/A</b>   |  |   |  |
| 21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT AT WORK <input checked="" type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>N/A</b>   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE<br><b>N/A Baltimore Maryland</b>  |  |   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>April 13, 1982</b> to <b>April 13, 1982</b> , that (I) (we) lost <b>the deceased</b> on <b>April 13, 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.) |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Alfonso H. Jaramila MD</b>  |  |   |  | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>4/13/82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Alfonso H. Jaramila MD</b>   |  |   |  | 22e. ADDRESS<br><b>2412 W Rogers Ave / Suite 16, Mt Airy, MD 21209</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>4-17-1982</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moreland Memorial</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>  |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS<br><b>Ruck Towson Funeral Home, Inc., Towson, Maryland</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 16 1982</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>James J. [Signature]</b>   |  |

08753

April 13 1954

CAUCASIAN I 2 1954

LARRY AND BALTHORE ST JOSEPH HOSPITAL  
X MEDICINE ROAD

*[Faint handwritten notes]*

D. L. Bell

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APR 18 1954

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.DHMH - 16 50M 1/81  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |   |  |   |   |   |  | 8 2 0 8 7 2 4                                |  |
|--|--|--|--|---|--|---|---|---|--|--|--|
| 1 - STATE REGISTRAR  |  |  |  |   |  |   |   |   |  | REG. NO.                                     |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Malcolm MAC PHAIL</b>  |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 4, 1982</b>                             |   |   | 2b. HOUR<br><b>5:40a</b> M   |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>09 13 1896</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>85</b> YRS.                                       |   | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS.<br>HOURS MIN.               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Scotland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                     |   |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rossville</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Square Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Steel worker</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Beth. Steel</b>   |  |  |  |
| 13a. STATE<br><b>Maryland</b>  |  |  | 13b. COUNTY<br><b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>Rosedale</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>21237 7617 Philadelphia Road</b>   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Murdo MacPhail</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary MacKiever</b> |   |  |   |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  |  | 16b. SOCIAL SECURITY NO.<br><b>213-07-9146</b>                         |   |  | 17. INFORMANT ADDRESS<br><b>Elizabeth MacPhail 7617 Philadelphia</b>                    |   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Gastrointestinal bleeding</b><br><b>2387</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Severe thrombocytopenia and anemia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Myeloproliferative disorder</b>   |  |  |  |   |  |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |   |   |   |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |   |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |   |   |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>April 3</b> , 19 <b>82</b> , to <b>April 4</b> , 19 <b>82</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>April 4</b> , 19 <b>82</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. |  |  |  |   |  |   |   |   |  |  |  |
| 22b. SIGNATURE<br><b>Tun M.D.</b>  |  |  |  |   |  | DEGREE<br><b>M.D.</b>   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>4/4/82</b>            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Tun</b>  |  |  |  |   |  | 22e. ADDRESS<br><b>9000 Franklin Square Drive 21237</b>                                 |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>4/7/82</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moreland Mem. Park</b>                |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Parkville Baltimore Md.</b>                    |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Lassahn F H 7401 BELAIR RD</b>  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 8 1982</b>                                      |   | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |  |  |

MEDICAL CERTIFICATION

458028

BP

DHMH - 16 50M 1/B1  
(VRS 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer's death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |   |  |
|---|--|---|--|---|--|--|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | 8 2 0 8 7 2 5<br>REG. NO.   |  | 1. DECEASED NAME<br>(TYPE OR PRINT)<br>EDITH S. MAHONEY   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>4 25 82   |  | 2b. HOUR<br>8:55P <sup>M</sup>                                      |  |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8 4 97  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>84 YRS  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Iowa   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore Co. MD.  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>TOWSON   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>GREATER BALTIMORE MEDICAL CTR.   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home  |  |   |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Harford  |  | 13c. CITY OR TOWN<br>Bel Air  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                       |  | 13e. STREET ADDRESS<br>1509 Balmoral Drive                          |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Arbuckle Shepherd  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Ida Jane Wilson  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>--   |  | 17. INFORMANT<br>John S. Mahoney -                                  |  |
| 16c. ADDRESS<br>1509 Balmoral Drive<br>Bel Air, Maryland  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) SEPSIS<br>4860<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) DUE TO, OR AS A CONSEQUENCE OF PNEUMONIA<br>(c) DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>3 DAYS<br>3 DAYS |  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                         |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from APRIL 22 19 82, to APRIL 25 19 82, that (I) (we) lost<br>saw the deceased alive on APRIL 25 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE<br>Kelly Reid MD   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED<br>4-25-82  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DR. KELLY REID   |  | 22e. ADDRESS<br>Greater Baltimore Medical Center<br>6701 N. Charles Street - Towson, Maryland   |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>4/28/82  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Parklawn Memorial Park  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Rockville, Maryland  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Jos. Gawler's Sons, Inc.<br>5130 Wisconsin Avenue, N.W.-Washington, D.C.  |  | 25. DATE REC'D BY REGISTRAR<br>MAY 3 1982   |  | 26. REGISTRAR'S SIGNATURE<br>[Signature]  |  |  |  |   |  |

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FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 / 2 6

REG. NO.

|  |  |   |                 |   |   |  |                     |  |  |
|--|--|---|-----------------|---|---|--|---------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST<br>JOHN   | MIDDLE<br>LOUIS | LAST<br>MALEC, Sr.  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>April 14, 1982 |  | 2b. HOUR<br>2:27a M |  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White  |                 | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>6 7 1926  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>55 YRS  |                     | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |                 | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.   |                     |  |  |
| 10. CITY OR TOWN OF DEATH<br>Rossville   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Franklin Square Hospital |                 |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Truck Driver   |                     | 12b. KIND OF BUSINESS OR INDUSTRY<br>Self Employed   |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Baltimore  |                 | 13c. CITY OR TOWN<br>Rosedale   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                     | 13e. STREET ADDRESS<br>7404 Regal Road   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Thomas Malec   |  |   |                 | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Josephine  |   |  |                     |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>220-14-3534   |                 | 17. INFORMANT<br>Susan A. Hamrick   |   | ADDRESS<br>7404 Regal Road<br>Balto., MD. 21237  |                     |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Complete Heart Block; Ventricular Fibrillation<br>4/49<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Coronary Artery Disease<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Congestive Heart Failure<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                                |  |   |                 |   |   |  |                     |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |                 |   |   |  |                     |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                 |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |   |  |                     |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |                 | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |                     |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 14, 1982, to April 14, 1982, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on April 14, 1982, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. |  |   |                 |   |   |  |                     |  |  |
| 22b. SIGNATURE<br>Michael A. Stang MD.   |  |   |                 | DEGREE<br>MD  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                     | 22c. DATE SIGNED<br>4-14-82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Michael A. Stang  |  |   |                 | 22e. ADDRESS<br>9000 Franklin Square Drive 21237  |   |  |                     |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>4/17/1982  |                 | 23c. NAME OF CEMETERY OR CREMATORY<br>Sacred Ht. Of Jesus   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland   |                     |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Duda-Ruck, Inc   |  |   |                 | ADDRESS<br>7922 Wise Avenue Dundalk, MD. 21222  |   | 25a. DATE REC'D. BY REGISTRAR<br>APR 19 1982   |                     | 25b. REGISTRAR'S SIGNATURE<br>James J. Nathan  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1971





TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  |  |   |  |  |  | 8 2 0 8 7 2 7 |  |
|---|--|---|--|--|--|---|--|--|--|---------------|--|
| 1. FOR STATE REGISTRAR  |  | REG. NO.  |  |  |  |   |  |  |  |               |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><i>Wilhemina Margaret Malkus</i>   |  |   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>4 / 4 / 82</i>   |  | 2b. HOUR<br><i>4:35 P.M.</i>                           |  |               |  |
| 3 SEX<br><i>Female</i>  |  | 4 RACE<br><i>White</i>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><i>10 24 1899</i>   |  | 6 AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS<br><i>82</i>  |  | IF UNDER 1 YEAR IF UNDER 24 HRS.                       |  |               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Germany</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore County</i> MD.  |  |  |  |               |  |
| 10. CITY OR TOWN OF DEATH<br><i>Rossville</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Manor Care Rossville</i> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Housewife</i>                                       |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Homemaking</i> |  |               |  |
| 13a. STATE<br><i>Maryland</i>   |  | 13b. CITY OR TOWN<br><i>Baltimore</i>   |  | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13d. STREET ADDRESS<br><i>4219 Parkmont Avenue 21206</i>  |  |  |  |               |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br><i>George Horeth</i>  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><i>Bertha Wilhelm</i>   |  |  |  |   |  |  |  |               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><i>No</i>  |  | 16b. SOCIAL SECURITY NO.<br><i>214-22-1960</i>  |  | 17 INFORMANT<br><i>Lillian Malkus</i>  |  | ADDRESS<br><i>310 Gatewater Court Glen Burnie 21061</i>   |  |  |  |               |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Concognitive Heart failure</i><br><i>4292</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <i>Aspiration Pneumonia.</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>Asc-V.D. chronic atrial fibrillation</i><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>6 hours.</i><br><i>24 hours.</i> |  |   |  |  |  |   |  |  |  |               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><i>C.V.A. with Rt hemiplegia Aphasia, History of Ca colon &amp; Ca Breast</i>  |  |   |  |  |  |   |  |  |  |               |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |               |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |  |  |               |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |               |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <i>3/26/1982</i> to <i>4/4/1982</i> , that (we) lost <i>saw</i> the deceased alive on <i>4/4/1982</i> and that in <i>our</i> (our) opinion death occurred on the date and hour and from the causes stated above, <i>in</i> (we) (did) <i>not</i> view the body after death.   |  |   |  |  |  |   |  |  |  |               |  |
| 22b. SIGNATURE<br><i>[Signature]</i>  |  | DEGREE<br><i>MD</i>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                 |  | 22c. DATE SIGNED  |  |  |  |               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>ICHIN - M. TUN</i>  |  | 22e. ADDRESS<br><i>2110 Pot spring Road Balto. Md 21093</i>   |  |  |  |   |  |  |  |               |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>  |  | 23b. DATE<br><i>4/6/82</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Gardens of Faith</i>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><i>Overlea Baltimore Md.</i>   |  |  |  |               |  |
| 24. FUNERAL DIRECTOR NAME<br><i>Lassahn Funeral Home</i>  |  | ADDRESS<br><i>7401 Belair Road</i>  |  | 25a. DATE REC'D. BY REGISTRAR<br><i>APR 6 1982</i>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |  |  |               |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 77 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 7 2 0 8 7 2 8   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME FIRST MIDDLE LAST<br>Charles Ferdinand Mandler  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>4-27-82   |  | 2b. HOUR<br>10:15 P M  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>6 12 09  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS<br>72   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore Co. MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>4014 Mar Jeff Pl. Apt C |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>steelworker  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Beth. Steel   |  |
| 13a. STATE<br>Md.  |  |   |  | 13b. COUNTY<br>Balto.   |  | 13c. CITY OR TOWN<br>Balto.  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Charles Howard Mandler  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Nellie Stone  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>no  |  | 16b. SOCIAL SECURITY NO.<br>216-01-1317   |  | 17. INFORMANT ADDRESS<br>Miss Shirley R. Mandler<br>5361 Essex Ct. Apt 252 Alex Va 22311  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Myocardial infarction</u><br>4100<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerotic cardiovascular disease</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>4 hrs. |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><u>Macrocytic anemia.</u>   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from Jan 19 82 to Apr 19 82, that (I) (we) last saw the deceased alive on Apr 24 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>Charles M. Kerr MD   |  |   |  | DEGREE<br>MD  |  | 22c. DATE SIGNED<br>Apr 28, 82   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Charles M. Kerr MD  |  |   |  | 22e. ADDRESS<br>6801 Belair Rd Balt. Md.  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>4-28-82  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Parkwood Cem.   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore Balto. Md.  |  |
| 24. FUNERAL DIRECTOR NAME<br>Lassahn Funeral Home Inc.   |  |   |  | 25. DATE RECEIVED BY REGISTRAR (SEE REGISTRAR'S SIGNATURE)<br>MAY 3 1982  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

|   |  |   |  |   |   |
|---|--|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Arthur P MARKLAND</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 15, 1982</b>                           |   | 2b. HOUR<br><b>9:50a<sub>M</sub></b>            |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>MARCH 11 1913</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b><br>YRS. MONTHS DAYS HOURS MIN.                                   |   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN)<br><b>MD</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County MD.</b>   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Rossville</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>FRANKLIN Sq Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Service man</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>oil</b> |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY<br><b>BALTO</b>   | 13c. CITY OR TOWN<br><b>Perry Hall</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>               |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Wilber S. MARKLAND</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MARY Howark</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b> |   |
| 16b. SOCIAL SECURITY NO.<br><b>215-07-4850</b>  |  | 17. INFORMANT<br><b>Fam. L. Records</b>   |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Multiple Cardiac Arrhythmias</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Status Post Myocardial Infarction</b>  |  |   |  |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                          |   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)    |  |   |   |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>March 26</b> , 19 <b>82</b> , to <b>April 15</b> , 19 <b>82</b> , that <input checked="" type="checkbox"/> (we) lost<br>saw the deceased alive on <b>April 15</b> , 19 <b>82</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated<br>above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. |  |   |  |   |   |
| 22b. SIGNATURE<br><b>Jose Munoz, M.D.</b>   |  | DEGREE<br><b>M.D.</b>   |  | 22c. DATE SIGNED<br><b>4/15/82</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Jose Munoz, M.D.</b>  |  | 22e. ADDRESS<br><b>9000 Franklin Square Dr. Balto., MD 21237</b>  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>4/19/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Park Road</b>  |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO MD</b>   |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>EVANS FUNERAL Chapel 8800 Harford Rd</b>   |  |   |   |
| 25a. DATE REC'D. BY REGISTRAR<br><b>APR 20 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Francis J. Anthony</b>   |  |   |   |

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1. The first part of the report  
describes the general situation  
of the project and the work  
done during the last year.  
It also mentions the results  
of the various experiments  
and the conclusions drawn from  
them.



2. The second part of the report  
describes the results of the  
experiments and the conclusions  
drawn from them. It also  
mentions the work done during  
the last year and the results  
of the various experiments.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |   |  |  |  |   |  |   |  | REG. NO. 08730   |  |   |  |
|--|--|---|--|--|--|---|--|---|--|--|--|---|--|
| 1- FOR STATE REGISTRAR   |  |   |  |  |  |   |  |   |  | 2a. DATE KNOWN OF DEATH  |  | 2b. HOUR                                |  |
| 1. DECEASED NAME (TYPE OR PRINT) <u>RICHARD Holloway MARSHALL</u>  |  |   |  |  |  |   |  |   |  | 2c. DATE PRONOUNCED DEAD <u>April 2 1982</u>   |  | 2d. HOUR <u>10 PM</u>                   |  |
| 3. SEX <u>Male</u>   |  | 4. RACE <u>White</u>                    |  | 5. DATE OF BIRTH <u>4-3-1934</u>   |  | 6. AGE (IN YEARS) <u>47</u> YRS.  |  | IF UNDER 1 YR. MONTHS DAYS HOURS MIN.   |  | 7c. DATE PRONOUNCED DEAD <u>April 2 1982</u>   |  | 7d. HOUR <u>10 PM</u>                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Virginia</u>  |  |   |  | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore Co.</u> MD.  |  |   |  |
| 10. CITY OR TOWN OF DEATH <u>Baltimore</u>   |  |   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>St. Joseph Hospital</u> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Waterman</u>   |  | 12b. KIND OF BUSINESS OR INDUSTRY <u>Seaford</u>   |  |   |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |  |  |   |  |   |  | 13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                     |  | 13b. STREET ADDRESS <u>Stout Street</u> |  |
| 13a. STATE <u>MD</u>   |  | 13c. CITY OR TOWN <u>Greenbackville</u> |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                       |  | 13e. STREET ADDRESS <u>Stout Street</u>                                       |  |   |  |  |  |   |  |
| 14. FATHER'S NAME (FIRST MIDDLE LAST) <u>William H Marshall Sr</u>   |  |   |  |  |  |   |  |   |  | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) <u>Huntle Holloway</u>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <u>No</u>   |  |   |  | 16b. SOCIAL SECURITY NO. <u>214-32-1875</u>  |  | 17. INFORMANT ADDRESS <u>Dorothy C Marshall - Greenbackville MD</u>           |  |   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>4110</u><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <u>Coronary Insufficiency</u><br>(c) <u>HSCD</u> |  |   |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>2+ yrs</u>  |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |   |  |  |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |   |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                |  |   |  |  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  |  |   |  |  |  |   |  |   |  | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> |  | and in my opinion                       |  |
| ACTUAL SIGNATURE <u>Charles O'Donnell</u>  |  |   |  | TITLE (SPECIFY) <u>Deputy</u>  |  |   |  | DATE SIGNED <u>4/2/82</u>   |  |  |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <u>CHARLES O'DONNELL</u>   |  |   |  | ADDRESS  |  |   |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>  |  |   |  | 23b. DATE <u>4-4-1982</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Greenbackville Cem</u>                  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Greenbackville Accomack Co. VA</u>   |  |  |  |   |  |
| 24. FUNERAL DIRECTOR NAME <u>Rich</u>  |  |   |  | ADDRESS <u>Temperanceville R 23442</u>   |  | 25a. DATE REC'D. BY REGISTRAR <u>APR 13 1982</u>                              |  | 25b. REGISTRAR'S SIGNATURE <u>James J. ...</u>  |  |  |  |   |  |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |   |  |   |  |   |  |                    |
|---|--|--|--|---|--|---|--|---|--|--------------------|
| 8-2 08731<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |   |  |                    |
| REG. NO.  |  |  |  |   |  |   |  |   |  |                    |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>SHANNA MARSHALL  |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>4 24 82   |   |  |   |  | 2b. HOUR<br>9:17 A |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>6 30 70   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>11   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |                    |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>California   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.                                    |  |   |  |                    |
| 10. CITY OR TOWN OF DEATH<br>TOWSON   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>GBMC=6701 N. CHARLES STREET |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Student                     |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>---  |  |                    |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |   |  |   |  |   |  |                    |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>102 Cotswold Road  |  |                    |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Shel Silverstein  |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Susan Taylor  |   |  |   |  |                    |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>---                         |  | 17. INFORMANT<br>ADDRESS<br>Dr. Curtis Marshall, Balto., Md.  |  |   |  |   |  |                    |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) MASSIVE CEREBRAL EDEMA<br>2396<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) HEMORRHAGE INTO BRAIN TUMOR<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |   |  |   |  |   |  |                    |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |   |  |   |  |                    |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                       |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                    |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |   |  |                    |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                 |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |                    |
| 22a. I certify that (this hospital) attended the deceased from 4-24-82, 19 82, to 4-24, 19 82, that (we) last saw the deceased alive on 4-24, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                 |  |  |  |   |  |   |  |   |  |                    |
| 22b. SIGNATURE<br>John E. Adams   |  |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |  | 22c. DATE SIGNED<br>4-24-82   |  |                    |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>JOHN E. ADAMS, M.D.  |  |  |  |   | 22e. ADDRESS<br>6701 NORTH CHARLES STREET-GBMC   |   |  |   |  |                    |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation   |  | 23b. DATE<br>4/26/82   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Green Mount   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto., Md.                                       |  |   |  |                    |
| 24. FUNERAL DIRECTOR<br>NAME<br>Henry W. Jenkins & Sons Co.<br>4905 York Road Balto., Md. 21212   |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>APR 26 1982   |   |  |   |  |                    |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |  |  | 8 2 0 8 7 3 2                     |  |
|---|--|--|--|---|--|---|--|--|--|-----------------------------------|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | REG. NO.   |  |   |  |   |  |  |  |                                   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST<br>JETTA   |  | MIDDLE<br>BOYD  |  | LAST<br>MARTIN  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>APRIL 7, 1982   |  | 2b. HOUR<br>P.M.<br>11:25         |  |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>APRIL 7, 1892   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>90 yrs. YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>NORTH DAKOTA   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.                                    |  |  |  |                                   |  |
| 10. CITY OR TOWN OF DEATH<br>TOWSON   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>DULANEY TOWSON NURSING CENTER |  |   |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOMEMAKER  |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| 13a. STATE<br>MARYLAND  |  | 13b. COUNTY<br>BALTO.  |  | 13c. CITY OR TOWN<br>TOWSON   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>1504 JEFFERS RD. 21204  |  |                                   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>JOHN BOYD   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>BELLE SWARTS   |  |   |  |  |  |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>224.62.4762T  |  | 17. INFORMANT<br>ADDRESS<br>Marlin C. Martin, Jr. (Son) (Same as 13e)   |  |   |  |  |  |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) MYOCARDIAL FAILURE<br>4140<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) ARTERIOSCLEROTIC HEART DISEASE<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>48 HRS |  |  |  |   |  |   |  |  |  |                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |  |   |  |   |  |  |  |                                   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |  |  |                                   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |                                   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from SEPT 1, 19 80, to APR 7, 19 82, that (I) (we) last saw the deceased alive on 4/6/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did not) view the body after death.)  |  |  |  |   |  |   |  |  |  |                                   |  |
| 22b. SIGNATURE<br>T. C. Siwinski  |  |  |  | DEGREE<br>MD  |  |   |  | 22c. DATE SIGNED<br>4/8/82   |  |                                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>T. C. SIWINSKI   |  |  |  | 22e. ADDRESS<br>206 W. PENNA. AV TOWSON Md 21204  |  |   |  |  |  |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>CREMATION   |  | 23b. DATE<br>4/8/1982  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Green Mount Crematory   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland                                |  |  |  |                                   |  |
| 24. FUNERAL DIRECTOR<br>Walter Brooks Bradley Inc., Balto., Md. 21222   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>APR 15 1982  |  | 25b. REGISTRAR'S SIGNATURE<br>Phyllis J. K... ..   |  |                                   |  |

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DATE: APRIL 7, 1964

WESTMORE COUNTY

JOHN W. DILLON, JR. & SONS

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST <u>Sharon</u> MIDDLE <u>Sue</u> LAST <u>Martin</u><br><u>SHARON</u> <u>MARTIN</u>   |  | 2a. DATE OF DEATH<br>MONTH <u>4</u> DAY <u>3</u> YEAR <u>82</u>  |  | 2b. HOUR<br><u>6:45 PM</u>  |  |
| 3. SEX<br><u>Female</u>  |  | 4. RACE<br><u>White</u>  |  | 5. DATE OF BIRTH<br>MONTH <u>7</u> DAY <u>12</u> YEAR <u>49</u>   |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><u>32</u>   |  | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>Maryland</u>  |  | 8. BALTIMORE CITY OR COUNTY OF DEATH<br><u>Baltimore County</u> MD.   |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>Baltimore County</u> MD.  |  | 10. CITY OR TOWN OF DEATH<br><u>Towson</u>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>Dulaney-Towson Nursing Home</u>       |  |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>12a. STATE <u>Maryland</u> 12b. COUNTY <u>Baltimore</u> 12c. CITY OR TOWN <u>Catonsville</u>   |  | 12d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  | 12e. STREET ADDRESS<br><u>74 Mellor Avenue 21228</u>  |  |
| 13. FATHER'S NAME<br>FIRST <u>Howard</u> MIDDLE <u>Louis</u> LAST <u>Martin</u>  |  | 14. MOTHER'S MAIDEN NAME<br>FIRST <u>Ramona</u> MIDDLE <u>Virginia</u> LAST <u>Everest</u>                                 |  | 15. SOCIAL SECURITY NO.<br><u>217-52-1357</u>   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <u>No</u>   |  | 16b. SOCIAL SECURITY NO.<br><u>217-52-1357</u>   |  | 17. INFORMANT<br><u>Mr. Howard L. Martin Same as # 13</u>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>ASPIRATION PNEUMONIA</u><br><u>3400</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>MULTIPLE SCLEROSIS</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>10 hrs</u><br><u>12 yw</u>   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <u>19</u>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Oct</u> , 19 <u>79</u> , to <u>4-3</u> , 19 <u>82</u> , that (I) (we) lost<br>saw the deceased alive on <u>3-24</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |
| 22b. SIGNATURE<br><u>Frederick J. Vollmer, MD</u>  |  | DEGREE<br><u>MD</u>  |  | 22c. DATE SIGNED<br><u>4/13/82</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>FREDERICK J. VOLLMER</u>   |  | 22e. ADDRESS<br><u>6100 YORK RD BALTIMORE 21212</u>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><u>Burial</u>  |  | 23b. DATE<br><u>4/7/82</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Meadowridge Mem Pk</u>   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><u>Burial</u>  |  | 23b. DATE<br><u>4/7/82</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Meadowridge Mem Pk</u>   |  |
| 23d. LOCATION<br>CITY OR TOWN<br><u>Elkridge</u>   |  | COUNTY<br><u>Howard</u>  |  | STATE<br><u>Md.</u>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>MacNabb Funeral Home</u>  |  | ADDRESS<br><u>Catonsville, Md.</u>   |  | 25a. DATE REC'D. BY REGISTRAR<br><u>APR 12 1982</u>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>MacNabb Funeral Home</u>  |  | ADDRESS<br><u>Catonsville, Md.</u>   |  | 25b. REGISTRAR'S SIGNATURE<br><u>James J. Nathan</u>  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

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STATE  
REGISTRAR XC 05 711 533

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|--|--|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>NORMAN LEE (MATTHEWS)</b>   |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4 4 82</b>  |  |   |  | 2b. HOUR<br><b>3:15 A.M.</b>  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>BLACK</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5 1 19</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS.<br><b>62</b>  |  | 7. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.                             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>NORTH CAROLINA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>TRUCK OPERATOR</b>       |  |
| 10. CITY OR TOWN OF DEATH<br><b>FORT HOWARD</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>V. A. MEDICAL CENTER</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>BETHLEHEM STEEL</b>   |  |   |  |   |  |
| 13a. STATE<br><b>MARYLAND</b>  |  |  |  | 13b. COUNTY<br><b>BALTIMORE</b>   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>LISTON MATTHEWS (MATHEWS)</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>EVELYN MILLER</b>   |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>YES WWII</b>            |  |   |  |
| 16a. SOCIAL SECURITY NO.<br><b>237 20 5725</b>   |  |  |  | 17. INFORMANT<br>ADDRESS<br><b>Katie M. Matthews 717 N. Longwood<br/>CLINICAL RECORDS, VAMC, FORT HOWARD, MD</b>  |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4380</b><br>IMMEDIATE CAUSE (a) <b>CEREBROVASCULAR ACCIDENT WITH APHASIA AND PARAPLEGIA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>BILATERAL PNEUMONIA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>2 1/2 YEARS</b><br><b>2 1/2 WEEKS</b>  |  |  |  |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>3 1/2 YEARS</b><br><b>2 1/2 WEEKS</b>     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>SEIZURE DISORDER, DIABETES MELLITUS, RECURRENT URINARY TRACT INFECTION</b>   |  |  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>11/15</b> , 19 <b>78</b> , to <b>4/4</b> , 19 <b>82</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>4/4</b> , 19 <b>82</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I/we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |   |  |
| 22a. SIGNATURE<br><b>Soon Ja Kim</b>   |  |  |  | DEGREE<br><b>M.D.</b>   |  |   |  | 22c. DATE SIGNED<br><b>4/4/82</b>   |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>SOON JA KIM, M. D.</b>   |  |  |  | 22e. ADDRESS<br><b>V.A.M.C., FORT HOWARD, MARYLAND 21052</b>  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>4/10/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Bonnie Field</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Saretan</b>  |  | 23e. DATE RECEIVED BY REGISTRAR<br><b>APR 5 1982</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H</b>  |  |  |  | ADDRESS<br><b>1101 E. North Ave.</b>  |  | 25. DATE RECEIVED BY REGISTRAR<br><b>APR 5 1982</b>   |  |   |  |

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CHARTER

WILLIAM

CHARTER

U.S.A.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified to come.

| Item 4 per phone 4/28/82 dad  |  |   |  | STATE OF MARYLAND   |  | 8 2 0 8 7 3 5  |  |
|---|--|---|--|---|--|--|--|
| 1. STATE REGISTRAR  |  |   |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |   |  | LAST  |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  |
| James Lamont<br>(BABY BOY)  |  |   |  | MAXWELL   |  | 4 19 82  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>Black American   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>4 17 '82  |  | 6. AGE (IN YEARS, LAST BIRTHDAY)<br>2 DAYS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Baltimore  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>TOWSON, MD.  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SINGLE FACILITY, GIVE STREET ADDRESS)<br>GBMC-6701 N. CHARLES ST.                 |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |
| 13a. STATE<br>Md  |  | 13b. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br>2607 W. Belvedere St. Apt 1c  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>James L Maxwell Sr.   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Theresa Felder   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>0   |  |  |  |
| 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS<br>James L Maxwell, 2607 W. Belvedere St  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardio Respiratory Arrest</u><br>7718<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>B strep. group B sepsis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-19 82 to 4-19 82, that (I) (we) lost saw the deceased alive on 4-19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>Z. Saleem Haque   |  | DEGREE MD<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>4-19-82   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ZAHIDA SALEEM HAQUE  |  | 22e. ADDRESS<br>GBMC Nursery  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>4. 21. 82  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>West-East View  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Md  |  |
| 24. FUNERAL DIRECTOR<br>Law Funeral Home 4611 Park Heights Ave.   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>APR 23 1982  |  |  |  |
|   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br>James J. Nathan   |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low required death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use on the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 / 3 6

REG. NO.

|  |  |   |   |  |  |
|--|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>KEITH D AVID MAXWELL MD</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>APRIL 26 1982</b>                                     |  | 2b. HOUR<br><b>8:30pm</b>  |
| 3. SEX<br><b>MALE</b>  | 4. RACE<br><b>WHITE</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>AUG. 20, 1947</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>34</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>GEORGIA</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. <b>XXX</b><br>MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>            | 9. <b>BALTIMORE CITY OR COUNTY OF DEATH</b><br><b>BALTIMORE COUNTY MD.</b>                      |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>LUTHERVILLE</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>4 TRELAWNY COURT</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>PHYSICIAN</b>            | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>MEDICINE</b>                                 |  |
| 13a. STATE<br><b>MARYLAND</b>  | 13b. COUNTY<br><b>BALTIMORE</b>  | 13c. CITY OR TOWN<br><b>LUTHERVILLE</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>4 TRELAWNY CT. #21093</b>                                  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>EARL LAVERNE MAXWELL, SR.</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>DR. GRACE RUSHING</b>   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>264-84-8228</b>  | 17. INFORMANT<br><b>MRS. LYNNE MAXWELL</b><br><b>4 TRELAWNY CT. LUTHERVILLE, MD 21093</b>       |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO PULMONARY ARREST.</b><br><b>1519</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>METASTATIC GASTRIC CARCINOMA.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)  |  |   |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>August 1981</b> , to <b>APRIL 26, 1982</b> , that (I) (we) lost<br>saw the deceased alive on <b>APRIL 26, 1982</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above (I) (we) (did) (did not) view the body after death.  |  |   |   |  |  |
| 22b. SIGNATURE<br><b>John Fetting M.D.</b>   |  | DEGREE<br><b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> <b>MEDICAL DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYSICIAN</b> <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>4/26/82.</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>John Fetting M.D.</b>  |  | 22e. ADDRESS<br><b>Johns Hopkins Oncology Center.</b>   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  | 23b. DATE<br><b>APR. 29, 1982</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTIMORE HEBREW</b>   | 23d. LOCATION<br><b>REISTERSTOWN BALTO. MD</b>  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>SOL LEVINSON &amp; BROS., INC.</b><br><b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 4 1982</b>  | 25b. REGISTRAR'S SIGNATURE<br><b>James J. [Signature]</b>                            |  |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. YOUR FILES, PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. RETURN TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN DIVISION 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |  |  | REG. NO. 08737   |  |
|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  |  |  |  |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Edwin T. Mays</b>   |  |  |  |  |  |  |  |  |  | 2a. DATE KNOWN OF DEATH<br>MONTH DAY YEAR<br><b>Apr 23 1982</b>  |  |
| 3. SEX <b>Male</b> 4. RACE <b>White</b> 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>June 17, 1892</b> 6. AGE (IN YEARS)<br>(LAST BIRTHDAY) YRS.<br><b>89</b>  |  |  |  |  |  |  |  |  |  | 2b. HOUR<br><b>11:30</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b> 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>  |  |  |  |  |  |  |  |  |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>Apr 23 1982</b>   |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County, MD</b>  |  |  |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Cockeysville</b> 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>9 Hillside Avenue</b>  |  |  |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Contractor - Highways</b>                |  |
| 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Cockeysville</b> 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  |  |  |  |  |  | 13e. STREET ADDRESS<br><b>9 Hillside Avenue</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Benjamin Howard Mays</b>  |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Sallie Wheeler</b>                                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br><b>No</b> 16b. SOCIAL SECURITY NO.<br><b>215-28-5281</b>   |  |  |  |  |  |  |  |  |  | 17. INFORMANT<br>ADDRESS<br><b>Mr. George P. Mays, Jr. Thurmont, Md.</b>                                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I DEATH WAS CAUSED BY:<br><b>4292</b> IMMEDIATE CAUSE (a) <b>ASCD</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b)<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Sudden</b>   |  |  |  |  |  |  |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |
| 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |  |  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <b>Charles F. O'Donnell, M.D.</b> TITLE (SPECIFY)<br><b>Deputy</b> MEDICAL EXAMINER   |  |  |  |  |  |  |  |  |  | DATE SIGNED <b>4/23/82</b>   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Charles F. O'Donnell, M.D.</b> ADDRESS <b>7501 York Road Towson, Md. 21204</b>  |  |  |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b> 23b. DATE<br><b>April 26, 1982</b> 23c. NAME OF CEMETERY OR CREMATORY<br><b>Jessops Methodist Cem.</b>  |  |  |  |  |  |  |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Sparks Baltimore, Maryland</b>                              |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Ruck Towson Funeral Home, Inc. Towson, Md. 21204</b>  |  |  |  |  |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 27 1982</b> 25b. REGISTRAR'S SIGNATURE<br><b>Frances Jean Wither</b> |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  |  |   |  |                     |  | 8 2 0 8 / 3 8                                |     |            |          |
|---|--|---|--|--|--|---|--|---------------------|--|--|-----|------------|----------|
| 1 - FOR STATE REGISTRAR   |  | REG. NO.  |  |  |  |   |  |                     |  |  |     |            |          |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST   |  | MIDDLE   |  | LAST  |  | 2a. DATE OF DEATH   |  | MONTH  | DAY | YEAR       | 2b. HOUR |
| JOSEPH  |  | I.  |  | MCCALMONT  |  |   |  | 4                   |  | 8  | '82 | 2:05A      |          |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR     |  | IF UNDER 24 HRS                              |     |            |          |
| MALE  |  | WHITE   |  | 2 08 '05   |  | 76 77   |  | MONTHS              |  | DAYS   |     | HOURS MIN. |          |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?                            |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                     |  |  |     |            |          |
| PA  |  | USA   |  |  |  | BALTIMORE COUNTY  |  |                     |  |  |     |            |          |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION |  | 12a. USUAL OCCUPATION  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                     |  |  |     |            |          |
| TOWSON  |  | GBMC-6701 N. CHARLES ST.                                |  | Steamfitter  |  | Heavy Construction  |  |                     |  |  |     |            |          |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS |  |  |     |            |          |
| Md.   |  | Balto,  |  | Parkton  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 635 Bee Tree Road   |  |  |     |            |          |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME                                |  |  |  |   |  |                     |  |  |     |            |          |
| Guy McCalmont   |  | Mary Hanna Hatch  |  |  |  |   |  |                     |  |  |     |            |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.                                |  | 17. INFORMANT  |  |   |  |                     |  |  |     |            |          |
| No  |  | 213-07-5623   |  | Vance McCalmont, Westminister, Md.   |  |   |  |                     |  |  |     |            |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4310 DUE TO, OR AS A CONSEQUENCE OF, (b) CEREBRAL HEMORRHAGE CEREBROVASCULAR ACCIDENT (c) HEMORRHAGIC CEREBROVASCULAR ACCIDENT   |  |   |  |  |  |   |  |                     |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |     |            |          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) (b) (c)  |  |   |  |  |  |   |  |                     |  |  |     |            |          |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED        |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |                     |  |  |     |            |          |
|   |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |                     |  |  |     |            |          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY                                     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |                     |  |  |     |            |          |
|   |  | HOUR A.M. MONTH DAY YEAR                                |  |  |  |   |  |                     |  |  |     |            |          |
|   |  | P.M. 19   |  |  |  |   |  |                     |  |  |     |            |          |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY                                    |  | 21f. LOCATION  |  |   |  |                     |  |  |     |            |          |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)          |  | STREET   |  | CITY OR TOWN  |  | COUNTY              |  | STATE  |     |            |          |
|   |  |   |  |  |  |   |  |                     |  |  |     |            |          |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-08 19 82, to 4-08 19 82, that (I) (we) lost the deceased alive on 4-08 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |   |  |                     |  |  |     |            |          |
| 22b. SIGNATURE  |  | DEGREE  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |  | 22c. DATE SIGNED  |  |                     |  |  |     |            |          |
| Samuel L. Jacobs  |  | MD  |  |  |  | 4/8/82  |  |                     |  |  |     |            |          |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS  |  |  |  |   |  |                     |  |  |     |            |          |
| SAMUEL L. JACOBS, M.D.  |  | GBMC-6701 N. CHARLES ST.                                |  |  |  |   |  |                     |  |  |     |            |          |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION   |  |                     |  |  |     |            |          |
| Burial  |  | April 10, 1982  |  | McCalmont Cemetery   |  | Parkton, Balto., Md.  |  |                     |  |  |     |            |          |
| 24. FUNERAL DIRECTOR  |  | 25a. DATE REC'D. BY REGISTRAR                           |  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |                     |  |  |     |            |          |
| J. J. Hartenstein   |  | APR 14 1982   |  | New Freedom, PA 17349  |  |   |  |                     |  |  |     |            |          |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by page 3.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 / 3 9

REG. NO.

|   |  |  |  |   |                           |   |  |  |  |
|---|--|--|--|---|---------------------------|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Mary W McCrobie</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4- 9- 82</b> |   | 2b. HOUR<br><b>6:20</b> M |   |  |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6 25 92</b>  |                           | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>89</b><br>YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                           | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>County Baltimore</b> MD.                             |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Riverview Nursing Centre</b> |  |   |                           | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Dundalk</b>   |                           | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>7000 A Morningson Road</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Not Known Woodrow</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Sophie Not Known</b>  |                           |   |  | ADDRESS <b>32 Eastship Road</b>  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br><b>162-22-7563</b>   |  | 17. INFORMANT<br>ADDRESS <b>Robert W. McCrobie, Sr. - Balto. MD 21222</b>   |                           |   |  |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Breast Carcinoma</b><br><b>4292</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |   |                           |   |  | ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>Breast Carcinoma, Esophagitis, Chronic Renal Failure</b>   |  |  |  |   |                           |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |                           | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                           |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                           |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |                           |   |  |  |  |
| 22b. SIGNATURE<br><b>Michael Schwartz M.D.</b>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |                           |   |  | 22c. DATE SIGNED<br><b>4/10/82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  | 22e. ADDRESS  |                           |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>4/13/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardens of Faith</b>   |                           | 23d. LOCATION<br>CITY OR TOWN<br><b>Baltimore</b>   |  | COUNTRY <b>Maryland</b> STATE  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Duda-Ruck, Inc.</b>  |  |  |  | ADDRESS<br><b>7922 Wise Avenue, Dundalk, MD 21222</b>   |                           | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 14 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |   |  |                                    |  |  |                   | 8 2 0 8 7 4 0   |  |
|--|--|--|--|---|--|------------------------------------|--|--|-------------------|---|--|
| 1. FOR STATE REGISTRAR   |  |  |  |   |  |                                    |  |  |                   | REG. NO.  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  |  |   | FIRST MIDDLE LAST  |                                    |  |  |                   | 2a. DATE OF DEATH   |  |
| JOSEPH J. MCGURRIN   |  |  |  |   |  |                                    |  |  |                   | MONTH DAY YEAR  |  |
| 3. SEX   |  |  |  |   | 4. RACE  |                                    | 5. DATE OF BIRTH   |  |                   | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  |
| MALE   |  |  |  |   | CAU  |                                    | MONTH DAY YEAR   |  |                   | 62  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |  |  |   | 7b. CITIZEN OF WHAT COUNTRY?   |                                    | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                   | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |
| PA   |  |  |  |   | U.S.A.   |                                    |  |  |                   | BALTIMORE COUNTY MD.  |  |
| 10. CITY OR TOWN OF DEATH  |  |  |  |   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                    |  |  |                   | 12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)        |  |
| TOWSON   |  |  |  |   | GBMC-6701 N. CHARLES ST.   |                                    |  |  |                   | ENGINEER  |  |
| 13a. STATE   |  |  |  |   | 13b. COUNTY  |                                    | 13c. CITY OR TOWN  |  |                   | 13d. INSIDE CITY LIMITS?  |  |
| Md   |  |  |  |   | BALTO  |                                    | TIMONIUM   |  |                   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME  |  |  |  |   | 15. MOTHER'S MAIDEN NAME   |                                    |  |  |                   | 13e. STREET ADDRESS   |  |
| FIRST MIDDLE LAST  |  |  |  |   | FIRST MIDDLE LAST  |                                    |  |  |                   | 1326 HARCROFT RD  |  |
| WILLIAM Mc GURRIN  |  |  |  |   | ELIZABETH GRINES   |                                    |  |  |                   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  |  |   | 16b. SOCIAL SECURITY NO.   |                                    | 17. INFORMANT ADDRESS  |  |                   |   |  |
| Yes  |  |  |  |   | NONE   |                                    | 176-16-7663 Family Records   |  |                   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:  |  |  |  |   |  |                                    |  |  |                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |  |
| IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST   |  |  |  |   |  |                                    |  |  |                   |   |  |
| 1629   |  |  |  |   |  |                                    |  |  |                   |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) LUNG CANCER   |  |  |  |   |  |                                    |  |  |                   |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |  |   |  |                                    |  |  |                   |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) METASTASIS TO BONE  |  |  |  |   |  |                                    |  |  |                   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).  |  |  |  |   |  |                                    |  |  |                   |   |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |                                    |  | 20a. AUTOPSY?  |                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |
|  |  |  |  |   |  |                                    |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |                   | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY   |  |                                    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                   |   |  |
|  |  |  |  | HOUR A.M. MONTH DAY YEAR  |  |                                    |  |  |                   |   |  |
|  |  |  |  | P.M. 19   |  |                                    |  |  |                   |   |  |
| 21d. INJURY OCCURRED   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |                                    |  | 21f. LOCATION  |                   |   |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  |   |  |                                    |  | STREET CITY OR TOWN COUNTY STATE   |                   |   |  |
|  |  |  |  |   |  |                                    |  |  |                   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 3-29, 1982, to 4-13, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |                                    |  |  |                   |   |  |
| 22b. SIGNATURE   |  |  |  |   |  |                                    |  | DEGREE   |                   | 22c. DATE SIGNED  |  |
| Elisa Brown Saltero  |  |  |  |   |  |                                    |  | MD   |                   | 4-13-82   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  |   |  |                                    |  | 22e. ADDRESS   |                   |   |  |
| ELISA BROWN-SALTERO  |  |  |  |   |  |                                    |  | GBMC-6701 N. CHARLES ST.   |                   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (S, E, F, Y)   |  |  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY |  |  | 23d. LOCATION     |   |  |
| BURIAL   |  |  |  | 4/16/82   |  | ST. CATHERINE                      |  |  | MARCON COUNTY PA. |   |  |
| 24. FUNERAL DIRECTOR NAME  |  |  |  |   |  |                                    |  | 25a. DATE REC'D. BY REGISTRAR  |                   | 25b. REGISTRAR'S SIGNATURE  |  |
| EVANS FUNERAL CHAPEL   |  |  |  |   |  |                                    |  | 8600 Harbor  |                   | APR 14 1982 James J. Nathan   |  |

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Items #18a-22a Film G569 7/23/82 STATE OF MARYLAND

FOR  
STATE  
REGISTRARDEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

8 2 0 8 7 4 1

|  |                  |  |  |   |  |   |  |  |  |  |  |  |  |
|--|------------------|--|--|---|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |                  | FIRST<br>MICHELE<br>Michelle   |  | MIDDLE<br>R.  |  | LAST<br>McKenna   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED XX 4 25 19 82   |  |  |  | 2b. HOUR<br>M                                      |  |
| 3. SEX<br>Female   | 4. RACE<br>White | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12/29/63   |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>18 YRS.   |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  |  | IF UNDER 24 HRS.   |  | 7c. DATE PRONOUNCED DEAD<br>4 26 19 82                   |  | 7d. HOUR<br>11:30 a. m.                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD.   |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County, MD.                                   |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Middle River  |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>517 Carrollwood Road |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>NONE                           |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |                  |  |  |   |  |   |  |  |  |  |  |  |  |
| 13a. STATE<br>MD.  |                  | 13b. COUNTY<br>BALTO   |  | 13c. CITY OR TOWN<br>MIDDLE RIVER   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>517 CARROLLWOOD   |  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>CHAS. P. McKENNA   |                  |  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>ELLEN L. HARTZELL                              |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>NO  |                  |  |  | 16b. SOCIAL SECURITY NO.<br>220 80 1163   |  | 17. INFORMANT ADDRESS<br>CHAS. McKENNA ABOVE  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Acute Opiate Intoxication<br>8500<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF                                       |                  |  |  |   |  |   |  |  |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |                  |  |  |   |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |                  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |  |  |  |  | 20. AUTOPSY?<br>YES XX NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>? P.M. 4/25/19 82  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>Subject Ingested drug |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK AT WORK   |                  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>Home   |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>517 Carrollwood Rd. Middle River Balto. Md.       |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                  |  |  |   |  |   |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE<br>Virginia L. Dolan  |                  |  |  |   |  | TITLE (SPECIFY)<br>M.D. Assistant   |  |  |  | MEDICAL EXAMINER<br>DATE SIGNED 4-26-82                  |  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Virginia L. Dolan, M.D.  |                  |  |  |   |  | ADDRESS<br>111 Penn Street  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |                  |  |  | 23b. DATE<br>4/29/82  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>LAKE VIEW   |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO. MD. |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>J.G. CONNELLY  |                  |  |  |   |  | ADDRESS<br>300 MACE   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>APR 29 1982             |  | 25b. REGISTRAR'S SIGNATURE<br>Rome J. [Signature]  |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING TO THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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Items 5; 13a-e; 14; 15 per phone

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 7 4 2

1. FOR 4/27/82 dad  
STATE  
REGISTRAR

REG. NO.

|   |  |   |   |  |   |   |
|---|--|---|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>KENDALL MCKOY</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4/1/82</b>  |  | 2b. HOUR<br><b>11 A M</b>   |   |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>Negro</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3/30/82 11:44pm</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>3-02</b> YRS.                                  | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>2</b>  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br><b>Md.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                  |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Greater Baltimore Medical Center</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY   |   |
| 13a. STATE<br><b>Md.</b>  | 13b. COUNTY<br><b>Balto.</b>   | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br><b>3314 Upton Road 21234</b>                                  |   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Robert Lee McKoy</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Brenda Mae Williams</b>   |   |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT ADDRESS  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>7470</b> IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <u>Persistent fetal circulation</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Patent ductus arteriosus</u> |  |   |   |  |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |   |  |   |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/30</b> , 19 <b>82</b> , to <b>4/1</b> , 19 <b>82</b> , that (I) (we) lost<br>saw the deceased alive on <b>4/1/82</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |   |   |  |   |   |
| 22b. SIGNATURE<br><i>Rudiger Breiteneker</i>  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |   |  | 22c. DATE SIGNED<br><b>4/1/82</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Rudiger Breiteneker, M.D.</b>   |  | 22e. ADDRESS<br><b>6701 N. Charles St., Balto, MD 21204</b>   |   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  | 23b. DATE<br><b>4/15/82</b>   | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Breiteneker</i>  |  | ADDRESS<br><i>GRME</i>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 19 1982</b>                                  |   | 25b. REGISTRAR'S SIGNATURE<br><i>Marie Jean Thacker</i> |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Possession here retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81  
(VRA 15, 4)1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 7 4 3

REG. NO.

|  |  |  |   |   |  |  |   |   |  |
|--|--|--|---|---|--|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>ALBERT J. MEEKINS.  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>04 15 82                             |   |  | 2b. HOUR<br>7 <sup>31</sup> P.M.   |   |   |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>CAUCASION   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12 04 00  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>81 YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.   |   |   |  |
| 10. CITY OR TOWN OF DEATH<br>Randallstown  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Baltimore County General Hospital |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Employee - Cloverland Dairy  |   |   |  |
| 13a. STATE<br>MD   |  | 13b. COUNTY<br>Baltimore   |   | 13c. CITY OR TOWN<br>Woodlawn   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 13e. STREET ADDRESS<br>2404 Birch Drive   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Nicholas S. Meekins  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary A. Smith  |  |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>-   |   | 17. INFORMANT<br>Mrs. Louise Meekins  |  | ADDRESS<br>2404 Birch Drive, Woodlawn, MD 21207  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIO-PULMONARY ARREST</u><br><u>4100</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>ACUTE MYOCARDIAL INFARCTION</u><br>(c) <u>CARDIOGENIC SHOCK</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |   |   |  |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>HYPERTENSION, RENAL FAILURE</u>  |  |  |   |   |  |  |   |   |  |
| 19a. DATE OF OPERATION<br>-  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>-                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. - 19                |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br>-  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>- |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>- - - - -   |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4-15-1982</u> to <u>4-15-1982</u> , that (I) (we) lost saw the deceased alive on <u>4-15-1982</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |   |   |  |  |   |   |  |
| 22b. SIGNATURE<br><u>Sudhir D. Patel</u>   |  |  |   |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br>4-15-82   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DR. SUDHIR D. PATEL   |  |  |   |   |  | 22e. ADDRESS<br>BAL. COUNTY GEN. HOSPITAL  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |  | 23b. DATE<br>4/19/82  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Olive Cemetery |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Randallstown Baltimore MD |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Loring Byers Funeral Directors, Inc.<br>8728 Liberty Rd., Randallstown, MD 21133   |  |  |   |   |  | 25a. DATE REC'D. BY REGISTRAR<br>APR 16 1982   |   | 25b. REGISTRAR'S SIGNATURE<br><u>Anna J. [Signature]</u>  |  |

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APR 10 1965

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. Pages 3 and 4 should be filed within 72 hours after death. Pages 5 and 6 should be filed within 72 hours after death. Pages 7 and 8 should be filed within 72 hours after death. Pages 9 and 10 should be filed within 72 hours after death. Pages 11 and 12 should be filed within 72 hours after death. Pages 13 and 14 should be filed within 72 hours after death. Pages 15 and 16 should be filed within 72 hours after death. Pages 17 and 18 should be filed within 72 hours after death. Pages 19 and 20 should be filed within 72 hours after death. Pages 21 and 22 should be filed within 72 hours after death. Pages 23 and 24 should be filed within 72 hours after death. Pages 25 and 26 should be filed within 72 hours after death. Pages 27 and 28 should be filed within 72 hours after death. Pages 29 and 30 should be filed within 72 hours after death. Pages 31 and 32 should be filed within 72 hours after death. Pages 33 and 34 should be filed within 72 hours after death. Pages 35 and 36 should be filed within 72 hours after death. Pages 37 and 38 should be filed within 72 hours after death. Pages 39 and 40 should be filed within 72 hours after death. Pages 41 and 42 should be filed within 72 hours after death. Pages 43 and 44 should be filed within 72 hours after death. Pages 45 and 46 should be filed within 72 hours after death. Pages 47 and 48 should be filed within 72 hours after death. Pages 49 and 50 should be filed within 72 hours after death. Pages 51 and 52 should be filed within 72 hours after death. Pages 53 and 54 should be filed within 72 hours after death. Pages 55 and 56 should be filed within 72 hours after death. Pages 57 and 58 should be filed within 72 hours after death. Pages 59 and 60 should be filed within 72 hours after death. Pages 61 and 62 should be filed within 72 hours after death. Pages 63 and 64 should be filed within 72 hours after death. Pages 65 and 66 should be filed within 72 hours after death. Pages 67 and 68 should be filed within 72 hours after death. Pages 69 and 70 should be filed within 72 hours after death. Pages 71 and 72 should be filed within 72 hours after death. Pages 73 and 74 should be filed within 72 hours after death. Pages 75 and 76 should be filed within 72 hours after death. Pages 77 and 78 should be filed within 72 hours after death. Pages 79 and 80 should be filed within 72 hours after death. Pages 81 and 82 should be filed within 72 hours after death. Pages 83 and 84 should be filed within 72 hours after death. Pages 85 and 86 should be filed within 72 hours after death. Pages 87 and 88 should be filed within 72 hours after death. Pages 89 and 90 should be filed within 72 hours after death. Pages 91 and 92 should be filed within 72 hours after death. Pages 93 and 94 should be filed within 72 hours after death. Pages 95 and 96 should be filed within 72 hours after death. Pages 97 and 98 should be filed within 72 hours after death. Pages 99 and 100 should be filed within 72 hours after death.

DHMH-16 50M 1/81  
(VRA 15, 4)1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 7 4 4

REG. NO.

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>BERNARD F MEISE   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>APRIL 25, 1982                          |  | 2b. HOUR<br>8:00A M  |
| 3. SEX<br>Male  | 4. RACE<br>White   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12 8 36   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>45 YRS.                                     | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Balto., Md.  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.                   |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ST. JOSEPH HOSPITAL |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Fabricator | 12b. KIND OF BUSINESS OR INDUSTRY<br>Westinghouse                                    |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE<br>Md.   |  |   | 13b. COUNTY<br>Balto.  | 13c. CITY OR TOWN<br>Balto.  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>George Meise  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Frances E. Knell              |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>yes   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>218-32-7639  | 17. INFORMANT<br>ADDRESS<br>201 Henry Ave. 21236<br>Mrs. Jacklene C. Meise     |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma of esophagus</u><br>1509<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)        |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (X) (this hospital) attended the deceased from April 7, 1982, to April 25, 1982, that (X) (we) last saw the deceased alive on April 25, 1982, and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (not) view the body after death.  |  |   |  |  |  |
| 22b. SIGNATURE<br><u>John E. Miller</u>   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br>4/25/82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>JOHN E. MILLER, M.D.   |  | 22e. ADDRESS<br>7620 YORK ROAD  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>4-28-82  | 23c. NAME OF CEMETERY OR CREMATORY<br>Gardens of Faith                         |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |
| 24. FUNERAL DIRECTOR<br>NAME<br>Lassahn Funeral Home  |  | ADDRESS<br>7401 Belair Rd.  |  | 25a. DATE REC'D. BY REGISTRAR<br>APR 29 1982   | 25b. REGISTRAR'S SIGNATURE<br><u>James J. Miller</u>   |

MEDICAL CERTIFICATION

29

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*Signature*



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 7 4 5

REG. NO.

|   |  |   |  |   |   |   |   |  |   |
|---|--|---|--|---|---|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FRANK Leo MERKLE   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>4-30-82                         |   |   | 2b. HOUR<br>12:01 am  |   |  |   |
| 3. SEX<br>Male  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Aug 29, 1918  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>63 YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pennsylvania   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.                                    |   |  |   |
| 10. CITY OR TOWN OF DEATH<br>TOWSON   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH CITY, STATE OR DISTRICT)<br>ST JOSEPH HOSPITAL |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Inspector                   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Balto Co. Govt.   |   |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |   |   |   |   |  |   |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Fullerton  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS<br>4235 Fowler Avenue  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Frank Merkle  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Margaret Cumisky |   |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes   |  | 16b. SOCIAL SECURITY NO.<br>WW 2  |  | 17. INFORMANT ADDRESS<br>Angela C. Merkle 4235 Fowler Avenue 21236  |   |   |   |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>pneumonia</u> PNEUMONIA<br>4292<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>ASCVD</u> ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF                       |  |   |  |   |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____   |  |   |  |   |   |   |   |  |   |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |   |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |   |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 4/19 to 4/30, 1982, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 4/30, 1982, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. |  |   |  |   |   |   |   |  |   |
| 22a. SIGNATURE<br>J. Lewis  |  |   |  |   | DEGREE<br>MD  |   | 22b. DATE SIGNED<br>4/30/82   |  | 22c. DATE SIGNED                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>JOFFRE LEWIS   |  |   |  |   | 22e. ADDRESS<br>7620 YORK ROAD TOWSON MD 21204                    |   |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |   | 23b. DATE<br>May 3, 1982   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Dulaney Valley Mem          |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Cockeysville, Balto. Co., Md. |  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>Dippel Funeral Homes, Inc.  |  |   |  |   | ADDRESS<br>7110 Belair Road<br>Baltimore, Md.                     |   | 25a. DATE REC'D. BY REGISTRAR<br>MAY 4 1982                                 |  | 25b. REGISTRAR'S SIGNATURE<br>James J. Nathan |

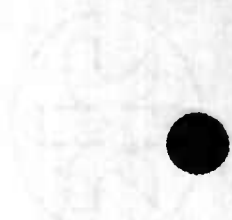
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Item 8 g567 5/5/82 gj

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 7 4 6

REG. NO.

|  |  |   |   |   |  |
|--|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>George C Meizger</b>  |  |   | 2a. DATE OF DEATH<br>MONTH <b>APRIL</b> DAY <b>3</b> YEAR <b>1982</b>       |   | 2b. HOUR <b>9:30</b> AM <b>A</b>   |
| 3. SEX<br><b>M</b>   | 4. RACE<br><b>W</b>  | 5. DATE OF BIRTH<br>MONTH <b>Dec</b> DAY <b>18</b> YEAR <b>1903</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b> YRS.                           |   | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN. <b></b>  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO CO MD</b>                  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Parkville</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>8206 Old Hartford Rd</b> | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>C. P. A.</b>   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Shipping</b>                        |   |  |
| 13a. STATE<br><b>MD</b>  |  | 13b. COUNTY<br><b>BALTO</b>   | 13c. CITY OR TOWN<br><b>Parkville</b>                                       | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br><b>8206 Old Hartford Rd</b>   |
| 14. FATHER'S NAME<br>FIRST <b>George</b> MIDDLE <b>C</b> LAST <b>Meizger</b> JR  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Anna</b> MIDDLE <b>Roth</b> LAST <b></b>   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>012-5-2591</b>   |   | 17. INFORMANT<br><b>Tam. L. Records.</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Diabetes Mellitus</b><br><b>2500</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b></b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b>   |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>30 years</b>  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>Cerebral arteriosclerosis + coronary artery dis</b>   |  |   |   |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>April 4</b> , 19 <b>77</b> , to <b>April 3</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>Nov 28</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |   |   |  |
| 22b. SIGNATURE<br><b>Donald Janary M.D.</b>  |  |   |   | 22c. DATE SIGNED<br><b>4-5-82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>R. DONALD JANDARF M.D.</b>   |  | 22e. ADDRESS<br><b>7403 Hartford Rd</b>   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  | 23b. DATE<br><b>4/6/82</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer</b>  | 23d. LOCATION<br>CITY OR TOWN <b>BALTO</b> COUNTY <b>MD</b> STATE <b>MD</b> |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>EVANS Funeral Chapel</b>  |  | ADDRESS<br><b>8800 Hartford Rd</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 14 1982</b>   | 25b. REGISTRAR'S SIGNATURE<br><b>James J. Nathan</b>   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar of Death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |   |  |  |  |  |  | 8 2 0 8 7 4 7 |  |
|---|--|---|--|---|--|--|--|--|--|---------------|--|
| 1 - FOR STATE REGISTRAR   |  |   |  |   |  |  |  |  |  | REG. NO.      |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>PENA E. MEYERS   |  |   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>4-13-1982   |  | 2b. HOUR<br>2:00 A.M.  |  |               |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>1-12-1902   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>80 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Baltimore Ind.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD  |  |  |  |               |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore Highlands  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>3006 Ohio Ave. 21227 |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Laborer  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Factory   |  |               |  |
| 13a. STATE<br>Ind   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br>106 S. Carlton St. 21223  |  |               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Alexander Dahl  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Margaret Dorsey  |  |  |  |  |  |               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WA 616261  |  | 17. INFORMANT<br>ADDRESS<br>Edward Meyer 5615 Mayview Ave. 21206  |  |  |  |  |  |               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 1749 Pulmonary failure<br>DUE TO, OR AS A CONSEQUENCE OF (b) Ca lung metastases<br>DUE TO, OR AS A CONSEQUENCE OF (c) Ca breast<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 week<br>6 months<br>3 yrs. |  |   |  |   |  |  |  |  |  |               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1   |  |   |  |   |  |  |  |  |  |               |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |               |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |               |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from MARCH 2 19 80, to MARCH 12 19 82, that (I) (we) last saw the deceased alive on MARCH 12 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |  |  |               |  |
| 22b. SIGNATURE<br>S. MuneSES  |  | SILVIO B. MUNESSES M.D. DEPT. OF HEALTH<br>TO CHICKORY COURT<br>BLEN ARM, MD. 21057<br>IRS NO. 520-90-9164                        |  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>4/13/82  |  |               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS  |  |   |  |  |  |  |  |               |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>4-16-1982  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore National Cem.   |  | 23d. LOCATION<br>OR TOWN COUNTY STATE<br>Baltimore Ind.  |  |  |  |               |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>John F. Crown & Son Inc.  |  | ADDRESS<br>Baltimore Ind. 21223<br>901 Hollins St.  |  | 25a. DATE REC'D. BY REGISTRAR<br>APR 14 1982  |  | 25b. REGISTRAR'S SIGNATURE<br>Harris   |  |  |  |               |  |

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*[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |   |                    | REG. NO.<br>8 2 0 8 7 4 8                    |  |
|--|--|---|--|---|--|---|--|---|--------------------|--|--|
| 1. FOR STATE REGISTRAR   |  | 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Harold JOSEPH MILWAY  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>April 25, 1982   |  |   | 2b. HOUR<br>3:08pm |  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>2 6 1919  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. 63  |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |                    | IF UNDER 24 HRS.<br>HOURS MIN.               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                    |  |   |                    |  |  |
| 10. CITY OR TOWN OF DEATH<br>Rossview  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Franklin Square Hos. |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Inspector                   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Western Elect.   |                    |  |  |
| 13a. STATE<br>Md.  |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Fullerton  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>Baltimore, Md.<br>4206 Klosterman Ave. 21236   |                    |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>James Hall Milway  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Rose L. Doyle  |  |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>W.W. 11 Yes W.W. 11               |                    |  |  |
| 16b. SOCIAL SECURITY NO.<br>216-18-9622  |  |   |  | 17. INFORMANT<br>Mrs. Edith L. Milway, Balto. Md.   |  |   |  | ADDRESS 4206 Klosterman Ave. 21236  |                    |  |  |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u><br>4100<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <u>Atherosclerotic Cardio-vascular Disease</u><br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF    |  |   |  |   |  |   |  |   |                    | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____   |  |   |  |   |  |   |  |   |                    |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                    |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |   |                    |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |                    |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Feb 24</u> , 19 <u>82</u> to <u>Apr 24</u> , 19 <u>82</u> , that (I) (we) lost<br>saw the deceased <u>die</u> on <u>Apr 24</u> , 19 <u>82</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (and) (I) (and) (we) view the body after death. |  |   |  |   |  |   |  |   |                    |  |  |
| 22b. SIGNATURE<br><u>[Signature]</u>   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |   |  | 22c. DATE SIGNED<br>4/27/82   |                    |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>A. E. Cocco MD</u>   |  |   |  | 22e. ADDRESS<br>Baltimore, Md.  |  |   |  |   |                    |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>4-29-1982  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Dulaney Valley  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Timonium Baltimore Md.                            |  |   |                    |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>E.F. Lassahn, 11750 Belair Rd. P.O. Box 147  |  |   |  | 25a. DATE BY REG. NO. 1982  |  |   |  | 25b. REGISTRAR<br>[Signature]   |                    |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |   |  |  | 8 2 0 8 / 4 9  |                                   |
|--|---|--|--|--|-----------------------------------|
| 1 - FOR STATE REGISTRAR  |   |  |  | REG. NO.   |                                   |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Elizabeth Minder</b>  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 16, 1982</b>                         |  | 2b. HOUR<br>M<br><b>4:30 A.</b>   |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>August 31, 1895</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b><br>YRS. MONTHS DAYS HOURS MIN.    |                                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.            |                                   |
| 10. CITY OR TOWN OF DEATH<br><b>Lutherville</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>14 Scottsdale Court</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |   |  | 13b. COUNTY<br><b>Baltimore</b>  | 13c. CITY OR TOWN<br><b>Lutherville</b>  |                                   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Frank Rosenberger</b>   |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Louisa Sands</b>                 |  |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>212-74-1524</b>   |  | 17. INFORMANT ADDRESS<br><b>Louis C. Minder 14 Scottsdale Court</b>            |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u><i>Uremia</i></u><br><b>4049</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u><i>Hypertensive Cardio Vascular Disease</i></u><br>DUE TO, OR AS A CONSEQUENCE OF (c) |   |  |  |  |                                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |   |  |  |  |                                   |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |                                   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |  |  |  |                                   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                   |
| 22a. I certify that (I) (the hospital) attended the deceased from <u><i>9-2-75</i></u> 19 <u><i>82</i></u> to <u><i>4/16/82</i></u> 19 <u><i>82</i></u> , that (I) (we) lost <u><i>4/15/82</i></u> 19 <u><i>82</i></u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) <u><i>view the body after death</i></u> .   |   |  |  |  |                                   |
| 22b. SIGNATURE<br><u><i>Kevin Quinn</i></u>  |   | DEGREE<br><u><i>M.D.</i></u>   |  | 22c. DATE SIGNED<br><u><i>4/16/82</i></u>                                      |                                   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Kevin Quinn, M.D.</b>  |   | 22e. ADDRESS<br><b>1205 York Rd.</b>   |  |  |                                   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |   | 23b. DATE<br><b>4-19-1982</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oaklawn Cemetery</b>                  |                                   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>  |   | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Ruck Towson Funeral Home, Inc. Towson, Md. 21204</b>  |  |  |                                   |
| 25. DATE REC'D BY REGISTRAR<br><b>APR 19 1982</b>  |   | 26. REGISTRAR'S SIGNATURE<br><u><i>James J. Nathan</i></u>   |  |  |                                   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director or page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item 4 g566 4/29/82 gj

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 7 5 0

REG. NO.

|   |  |  |  |   |  |  |   |
|---|--|--|--|---|--|--|---|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>MARIE M. MOHR  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>4 17 82 |   |  | 2b. HOUR<br>3:45 P.M.  |   |
| 3 SEX<br>Female   |  | 4 RACE<br>C White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>1 15 03   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>79 YRS.   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE County MD.  |   |
| 10. CITY OR TOWN OF DEATH<br>Towson   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ST. Joseph Hospital |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Seamstress  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Clothing  |   |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>21204  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |   |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Steigerwald   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Ament  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(IF YES, GIVE WAR OR DATES)<br>No   |  |  |   |
| 16b. SOCIAL SECURITY NO.<br>212-10-4888   |  | 17. INFORMANT ADDRESS<br>Norma E. Comotto Towson, MD 21204   |  |   |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4292 INTRACEREBRAL HEMORRHAGE<br>DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic cardiovascular disease<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 DAYS<br>Years |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |  |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |
| 22a. I certify that (I (this hospital) attended the deceased from April 15 19 82, to April 17 19 82, that (I (we) lost saw the deceased alive on April 17 19 82, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |   |
| 22b. SIGNATURE<br>Barry L. Rosen MD   |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED<br>4-17-82  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Barry L. Rosen M.D.  |  | 22e. ADDRESS<br>ST. JOSEPH Hospital  |  |   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>Apr. 20, '82  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Oak Lawn Cemetery   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Co., MD  |   |
| 24 FUNERAL DIRECTOR<br>NAME<br>William E. Johnson   |  | ADDRESS<br>8521 Loch Raven Blvd.   |  | 25a. DATE REC'D. BY REGISTRAR<br>APR 19 1982  |  | 25b. REGISTRAR'S SIGNATURE<br>James VanNathan  |   |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 27 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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|   |  |  |   |                                  |  |
|---|--|--|---|----------------------------------|--|
| 1. FOR STATE REGISTRAR  |  | 2a. DATE OF DEATH  |   | 2b. HOUR                         |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | 2a. DATE OF DEATH  |   | 2b. HOUR                         |  |
| WILHELM G. MOOK   |  | APRIL 8, 1982  |   | 12:30 P.M.                       |  |
| 3. SEX  | 4. RACE  | 5. DATE OF BIRTH   | 6. AGE (IN YEARS LAST BIRTHDAY)                                     | IF UNDER 1 YEAR                  |  |
| MALE  | WHITE  | APRIL 27, 1996   | 85  | IF UNDER 24 HRS                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?   | MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>        | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |                                  |  |
| GERMANY   | GERMANY  | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  | BALTIMORE COUNTY MD.  |                                  |  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |                                  |  |
| BALDWIN   | 4808 CARROLL MANOR ROAD  | WOOD WORK  | CARPENTER   |                                  |  |
| 13a. STATE  | 13b. COUNTY  | 13c. CITY OR TOWN  | 13d. INSIDE CITY LIMITS?  | 13e. STREET ADDRESS              |  |
| MO.   | BALTO.   | BALDWIN  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 4808 CARROLL MANOR ROAD          |  |
| 14. FATHER'S NAME   | 15. MOTHER'S MAIDEN NAME   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?                        |                                  |  |
| FRISORICH   | ELIZABETH  |  | 16b. SOCIAL SECURITY NO.  |                                  |  |
| 17. INFORMANT   | ADDRESS  |  |   |                                  |  |
| DO  | FAMILY RECORDS   |  |   |                                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |   |                                  |  |
| PART 1. DEATH WAS CAUSED BY:  |  |  |   |                                  |  |
| IMMEDIATE CAUSE (a) Renal Failure   |  |  |   |                                  |  |
| 4409 DUE TO, OR AS A CONSEQUENCE OF   |  |  |   |                                  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |   |                                  |  |
| (b) ARTERIO SCLEROSIS   |  |  |   |                                  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |   |                                  |  |
| (c)   |  |  |   |                                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |   |                                  |  |
| CONGESTIVE HEART FAILURE  |  |  |   |                                  |  |
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20a. AUTOPSY?  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |                                  |  |
| —   | —  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |                                  |  |
|   | HOUR A.M. MONTH DAY YEAR   |  |   |                                  |  |
|   | P.M. 19  |  |   |                                  |  |
| 21d. INJURY OCCURRED  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    | 21f. LOCATION  |   |                                  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | CITY OR TOWN COUNTY STATE  |   |                                  |  |
| 22a. I certify that (1) (the deceased) attended the deceased from October 1971, to 4-8 1982, that (1) (myself) saw the deceased alive on 4-7 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did not) view the body after death. |  |  |   |                                  |  |
| 22b. SIGNATURE  |  | DEGREE   |   | 22c. DATE SIGNED                 |  |
| F.R. Norris   |  | M.D.   |   | 4-12-82                          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |   |                                  |  |
| John R. Norris  |  | MANOR PROFESSIONAL BLDG, PHOSNIX   |   |                                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   | 23b. DATE  | 23c. NAME OF CEMETERY OR CREMATORY   | 23d. LOCATION   |                                  |  |
| BURIAL  | 4-12-1982  | DULANEY VALLEY   | T. Monium BALTO. MO.  |                                  |  |
| 24. FUNERAL DIRECTOR  |  | 25a. DATE REC'D. BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE       |  |
| NAME  |  | ADDRESS  |   |                                  |  |
| EVANS CHAPL OF CHIMES   |  | 2325 YORK ROAD   |   | APR 14 1982 Frances Jean Kestner |  |

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RECEIVED  
JAN 11 1954  
U.S. AIR FORCE



RECEIVED  
JAN 11 1954  
U.S. AIR FORCE

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FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 2 0 8 7 5 2  
CERTIFICATE OF DEATH

REG. NO.

|   |                         |   |  |   |  |   |   |  |
|---|-------------------------|---|--|---|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>PEARL C. MORAN</b>                      |                         |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4 8 82</b> |   |  | 2b. HOUR<br><b>5:10</b> A.M.  |   |  |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 7 1900</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                      |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                             |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Catonsville</b>                                   |                         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>801 Winters Lane Apt. 228</b> |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>---</b> |  |
| 13a. STATE<br><b>Maryland</b>   |                         | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Catonsville</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Unknown Christopher</b>              |                         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Unknown Beecham</b>   |  |   |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b> |                         | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>212-16-5145</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Frank D. Moran 1215 Circle Drive 21227</b>   |  |   |   |  |

|  |  |  |  |
|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic CA of uterus</b><br><b>1790</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
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|---|--|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>4/8 19 82</b>  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)  |  | 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                  |  |
| 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>4/8 19 82</b>  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>4/8 19 82</b> to <b>4/8 19 82</b> that (1) (we) lost above named person and that in my (our) opinion death occurred on the date and hour and from the causes stated |  |  |  |
| 22b. SIGNATURE<br><b>Herbert J. Levickas, M.D.</b>  |  | 22c. DATE SIGNED<br><b>4/8/82</b>  |  |
| 22d. PHYSICIAN'S NAME (IF DIFFERENT)  |  | 22e. ADDRESS<br><b>5404 East Drive 21227</b>   |  |

|   |  |                             |  |   |  |   |  |
|---|--|-----------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>4/10/82</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cemetery</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229</b> |  |                             |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 12 1982</b>               |  | 25b. REGISTRAR'S SIGNATURE<br><i>James J. [Signature]</i>               |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DHMH - 16 50M 1/81  
(VRA 15, 4)TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at (410) 327-1234.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |  |  | 8 2 0 8 7 5 3                                |  |  |  |
|--|--|--|--|---|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO.   |  |   |  |  |  |  |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Edward Lynd Morrow</i>  |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>April 1, 1982</i>  |  |  |  | 2b. HOUR<br><i>2:05A M</i>                   |  |  |  |
| 3. SEX<br><i>Male</i>  |  | 4. RACE<br><i>White</i>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>Dec. 18, 1889</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS.<br><i>92</i>   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br><i></i>  |  | IF UNDER 24 HRS.<br>HOURS MIN.<br><i></i>    |  |  |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Penn.</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore County</i> MD.  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Catonsville</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Summitt Nursing Home</i> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Accountant</i>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Standard Oil</i>   |  |  |  |  |  |
| 13a. STATE<br><i>Maryland</i>  |  | 13b. COUNTY<br><i>Howard</i>   |  | 13c. CITY OR TOWN<br><i>Elkridge</i>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS<br><i>5818 Hunt Club Road 21227</i>  |  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Edward F. Morrow</i>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Winifred Unknown</i>  |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>Yes</i>   |  | 16b. SOCIAL SECURITY NO.<br><i>WW 1</i>  |  | 17. INFORMANT<br><i>Mr. Ed Greasby</i>  |  | 17b. ADDRESS<br><i>5818 Hunt Club Road Elkridge, MD. 21227</i>   |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i><br><i>4292</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Arteriosclerotic Cardiovascular Disease</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(c) <i></i><br>DUE TO, OR AS A CONSEQUENCE OF |  |  |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><i>1. Osteoarthritis 2. Cerebral Ischemia</i>   |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Dec. 28, 1979</i> to <i>April 1, 1982</i> , that (I) (we) last saw the deceased alive on <i>March 31, 1982</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><i>James E. Rowe M.D.</i>  |  |  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><i>4/2/82</i>  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Dr. James Rowe</i>   |  |  |  |   |  | 22e. ADDRESS<br><i>413 Commonwealth Ave. Catonsville</i>   |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>  |  | 23b. DATE<br><i>4-3-82</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Druid Ridge Cemetery</i>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Pikesville, Balto. Maryland</i>   |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Loring Byers Funeral Directors, Inc.</i>  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><i>APR 5 1982</i>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>James E. Rowe</i>   |  |  |  |  |  |
| 24b. ADDRESS<br><i>8728 Liberty Road Randallstown, MD. 21133</i>   |  |  |  |   |  |  |  |  |  |  |  |  |  |

MEDICAL CERTIFICATION

6 4 8 4 2 0

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |  |  | 7 2 0 8 7 5 4                                |  |                          |  |
|---|--|--|--|--|--|---|--|--|--|--|--|--------------------------|--|
| 1. FOR STATE REGISTRAR  |  | REG. NO.   |  |  |  |   |  |  |  |  |  |                          |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST  |  | MIDDLE   |  | LAST  |  | 2a. DATE OF DEATH  |  | MONTH DAY YEAR                               |  | 2b. HOUR                 |  |
| RALEIGH   |  | C  |  | MOSS   |  | SR  |  | 4-29-82  |  |  |  | 1:30am M                 |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  |   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                |  | IF UNDER 1 YEAR                              |  | IF UNDER 24 HRS          |  |
| Male  |  | White  |  | Oct. 13, 1912  |  |   |  | 69 YRS.  |  | MONTHS DAYS                                  |  | HOURS MIN.               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |  |  |  | MD.                      |  |
| Maryland  |  | USA  |  |  |  |   |  | BALTIMORE COUNTY   |  |  |  |                          |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY            |  |                          |  |
| TOWSON  |  | ST. JOSEPH HOSPITAL  |  |  |  | Manager   |  |  |  | Taxi Co.                                     |  |                          |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13b. STATE   |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS  |  |  |  |                          |  |
| Maryland  |  | Baltimore  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 523 Rossiter Avenue   |  |  |  |  |  |                          |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |   |  | 16b. SOCIAL SECURITY NO.                                       |  | 17. INFORMANT                                |  |                          |  |
| Harvey  |  | Moss   |  | Minnette   |  | Kondner   |  | No   |  | 216 03 4605                                  |  | Mrs. Margaret Moss, Same |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                          |  |
| PART 1. DEATH WAS CAUSED BY:  |  |  |  |  |  |   |  |  |  |  |  |                          |  |
| IMMEDIATE CAUSE (a) CARDIAC ARRHYTHMIA  |  |  |  |  |  |   |  |  |  |  |  |                          |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |   |  |  |  |  |  |                          |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |  |  |  |   |  |  |  |  |  |                          |  |
| (b) SEVERE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE  |  |  |  |  |  |   |  |  |  |  |  |                          |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |   |  |  |  |  |  |                          |  |
| (c)   |  |  |  |  |  |   |  |  |  |  |  |                          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |   |  |  |  |  |  |                          |  |
| LONG STANDING CHRONIC OBSTRUCTIVE PULMONARY DISEASE   |  |  |  |  |  |   |  |  |  |  |  |                          |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |  |  |                          |  |
|   |  |  |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |  |  |                          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)  |  |   |  |  |  |  |  |                          |  |
|   |  | HOUR A.M. MONTH DAY YEAR   |  |  |  |   |  |  |  |  |  |                          |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION  |  |   |  |  |  |  |  |                          |  |
| WROTE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  |  | STREET   |  | CITY OR TOWN  |  | COUNTY   |  | STATE  |  |                          |  |
| 22a. I certify that (X) (this hospital) attended the deceased from 4-1 19 82 to 4-29 19 82; that (X) (we) lost the deceased alive on 4-29 19 82 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (not) view the body after death. |  |  |  |  |  |   |  |  |  |  |  |                          |  |
| 22b. SIGNATURE  |  | DEGREE   |  | 22c. DATE SIGNED   |  |   |  |  |  |  |  |                          |  |
| SAMUEL LEE, M.D.  |  |  |  | 4/29/82  |  |   |  |  |  |  |  |                          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  | 22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>          |  |   |  |  |  |  |  |                          |  |
|   |  | 7620 YORK ROAD TOWSON MD 21204   |  |  |  |   |  |  |  |  |  |                          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION   |  | COUNTY STATE   |  |  |  |                          |  |
| Cremation   |  | 4/30/82  |  | Green Mount  |  | Balto.,   |  | Md.  |  |  |  |                          |  |
| 24. FUNERAL DIRECTOR NAME   |  | 24b. ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |  |  |                          |  |
| Henry W. Jenkins & Sons Co.   |  | 4905 York Road Balto., Md. 21212   |  | MAY 3 1982   |  | Thane Jan...  |  |  |  |  |  |                          |  |

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1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

Stirling, 1900



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |   |  |  |  |  |  | 8 2 0 8 / 5 5 |  |
|--|--|--|--|---|--|--|--|--|--|---------------|--|
| 1. FOR STATE REGISTRAR   |  |  |  |   |  |  |  |  |  | REG. NO.      |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>THOMAS E. MOYLAN  |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>APRIL 27 1982 |  |  | 2b. HOUR<br>8:15 P.M.                        |  |               |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12 13 1899  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>82  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |  |               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.   |  |  |  |               |  |
| 10. CITY OR TOWN OF DEATH<br>Towson  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>DULANEY TOWSON NURSING CENTER |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Manufacture of Hats                                    |  | 12b. KIND OF BUSINESS OR INDUSTRY            |  |               |  |
| 13a. STATE<br>Md.  |  | 13b. COUNTY<br>Balto.  |  | 13c. CITY OR TOWN<br>Upperco  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  | 13e. STREET ADDRESS<br>5521 Emory Road       |  |               |  |
| 14. FATHER'S NAME<br>THOMAS  |  | 15. MOTHER'S MAIDEN NAME<br>HONORA   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>212-05-9537  |  | 17. INFORMANT<br>Mary Klunk                  |  |               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u><br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>SECONDS  |  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br>BRONCHOGENIC CARCINOMA  |  |  |  |  |  |               |  |
| 19a. DATE OF OPERATION<br>NONE   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>—  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |               |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |  |  |               |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11-11, 1981, to 4-27, 1982, that (I) (we) lost<br>saw the deceased alive on 4-21, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |  |  |  |               |  |
| 22b. SIGNATURE<br>Frederic J. Vollmer MD.  |  | DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br>4-27-82  |  |  |  |               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>FREDERIC J. VOLLMER MD  |  | 22e. ADDRESS<br>6100 YORK RD BALTIMORE MD, 21212   |  |   |  |  |  |  |  |               |  |
| 23a. BURIAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>Apr 29, 1982  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Evergreenman Grr  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Fry Ksburg Carroll Md  |  |  |  |               |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>A. J. Ehlhardt   |  | ADDRESS<br>Owings Mills, Md  |  | 25a. DATE REC'D BY REGISTRAR<br>APR 30 1982   |  |  |  |  |  |               |  |

2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 2681, 26

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 7 5 6

REG. NO.

|   |   |   |  |  |   |  |
|---|---|---|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Joseph MROZ</b>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 27, 1982</b>             |  | 2b. HOUR<br>a <b>3:00</b> m   |  |
| 3. SEX<br><b>M</b>  | 4. RACE<br><b>W</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12/12/96</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>85</b>   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>M.D.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>ROSSVILLE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>FRANKLIN SQ</b> |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>ENGINEER</b>  |   |  |
| 13a. STATE<br><b>M.D.</b>   |   |   | 13b. COUNTY<br><b>BALTO</b>  | 13c. CITY OR TOWN<br><b>ESSEX</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>A DABERT MROZ</b>  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>JULIA PIETROWSKI</b> |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>UNK</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>215054086</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>LULA MROZ ABOVE</b>                                   |   |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio-pulmonary Arrest</b><br><b>4280</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Congestive Heart Failure</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |   |   |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I<br><b>Pneumonitis</b>   |   |   |  |  |   |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>April 15</b> , 19 <b>82</b> , to <b>April 27</b> , 19 <b>82</b> , that <input checked="" type="checkbox"/> (we) lost <input type="checkbox"/> saw the deceased alive on <b>April 27</b> , 19 <b>82</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did <input type="checkbox"/> (we) did not the body after death. |   |   |  |  |   |  |
| 22b. SIGNATURE<br><b>Michael P. Gosney</b> MD<br>DEGREE   |   |   |  | 22c. DATE SIGNED<br><b>4/27/82</b>   |   | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Michael Gosney M.D.</b>  |
| 22e. ADDRESS<br><b>9000 Franklin Square Drive 21237</b>   |   |   |  | 22f. DATE REC'D. BY REGISTRAR<br><b>APR 28 1982</b>                                  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |   | 23b. DATE<br><b>4/30/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ST. STANISLAUS</b>                          |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO. MD.</b>  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>J.G. CONNELLY 300 MACE</b>   |   |   |  | 25a. REGISTRAR'S SIGNATURE<br><b>APR 28 1982</b>                                     |   |  |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

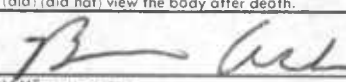

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/B1  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |   |  | 8 2 0 8 7 5 7  |  |
|--|--|--|--|---|--|---|--|---|--|--|--|
| 1 - FOR<br>STATE<br>REGISTRAR  |  | REG. NO.   |  |   |  |   |  |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>ANTOINETTE J. MUCHNA</b>  |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4 7 '82</b>   |  |   |  | 3b. HOUR<br><b>11:00 PM</b>  |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6 23 1895</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b>  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>YRS.  |  | IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Czech.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY MD.</b>                             |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>GBMC-6701 N. CHARLES ST.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>--</b>  |  |  |  |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>Towson, Md 21204<br/>922 Beaverbank Circle,</b>   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Albert Plos</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Anna Meyer</b>  |  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>--</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Clara A. Heilman, same as above</b>  |  |   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b>  |  |  |  |   |  |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH  |  |
| 1579<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }<br>(b) <b>PANCREATIC CARCINOMA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |  |  |   |  |   |  |   |  | 3-8-82   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |  |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3-05</b> , 19 <b>82</b> , to <b>4-07</b> , 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>4-07</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |   |  | 22c. DATE SIGNED<br><b>4/8/82</b>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BRIAN ADLER, M.D.</b>  |  |  |  | 22e. ADDRESS<br><b>GBMC-6701 N. CHARLES ST.</b>   |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>1982 April 10,</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md.</b>                             |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Schimunek Funeral Home<br/>3331 Brehms Lane, 21213</b>  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 12 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE<br> |  |  |  |

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## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |   |   |  |  |   |   |  |   |  |
|---|--|---|---|---|--|--|---|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>JANE M. Mullen</b>  |  |   |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>4-14-82</b>                             |  |   |   |  | 2b. HOUR<br><b>4:05 P.M.</b>                                  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>11-17-94</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>87</b> YRS.  |   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Balt. Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore CO</b> MD.  |   |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Stella Maris Hospice</b> |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>CLERK</b>  |   |   | 12b. KIND OF BUSINESS OR INDUSTRY  |   |  |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY   |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                       |   | 13e. STREET ADDRESS<br><b>1642 Rawlworth Rd.</b>                      |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>ARTHUR J. Mullen</b>  |  |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>UNKNOWN M<sup>rs</sup> Williams</b>  |  |  |   | ADDRESS<br><b>2500 Dulany Valley Towson, Md.</b>                      |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>215-09-0832</b>  |   | 17. INFORMANT<br><b>Stella Maris Hospice</b>  |  |  |   |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Vascular accident</b><br><b>4360</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |   |   |  |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 week</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |  |   |   |   |  |  |   |   |  |   |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |   |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>June 23, 1970</b> to <b>April 14, 1982</b> , that (I) (we) lost <b>saw</b> the deceased alive on <b>April 13, 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                     |  |   |   |   |  |  |   |   |  |   |  |
| 22b. SIGNATURE<br><b>Stephen K. Dyal</b>  |  |   |   |   |  | DEGREE<br><b>ATTENDING PHYSICIAN</b> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>4/14/82</b>                                    |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Stephen K. Dyal</b>   |  |   |   |   | 22e. ADDRESS<br><b>8501 LASalle Rd. #309 21204</b>                             |  |   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |   | 23b. DATE<br><b>4-17-82</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral Cemetery</b>            |  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b> |  |   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Ruck Towson Funeral Home, Inc. Towson, Md. 21204</b>  |  |   |   |   | ADDRESS<br><b>1050 York Rd.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 16 1982</b>                               |   | 25b. REGISTRAR'S SIGNATURE<br><b>Ann J. [Signature]</b>  |   |  |

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DHAH-16 50M 1/81  
(VRA 15, 4)

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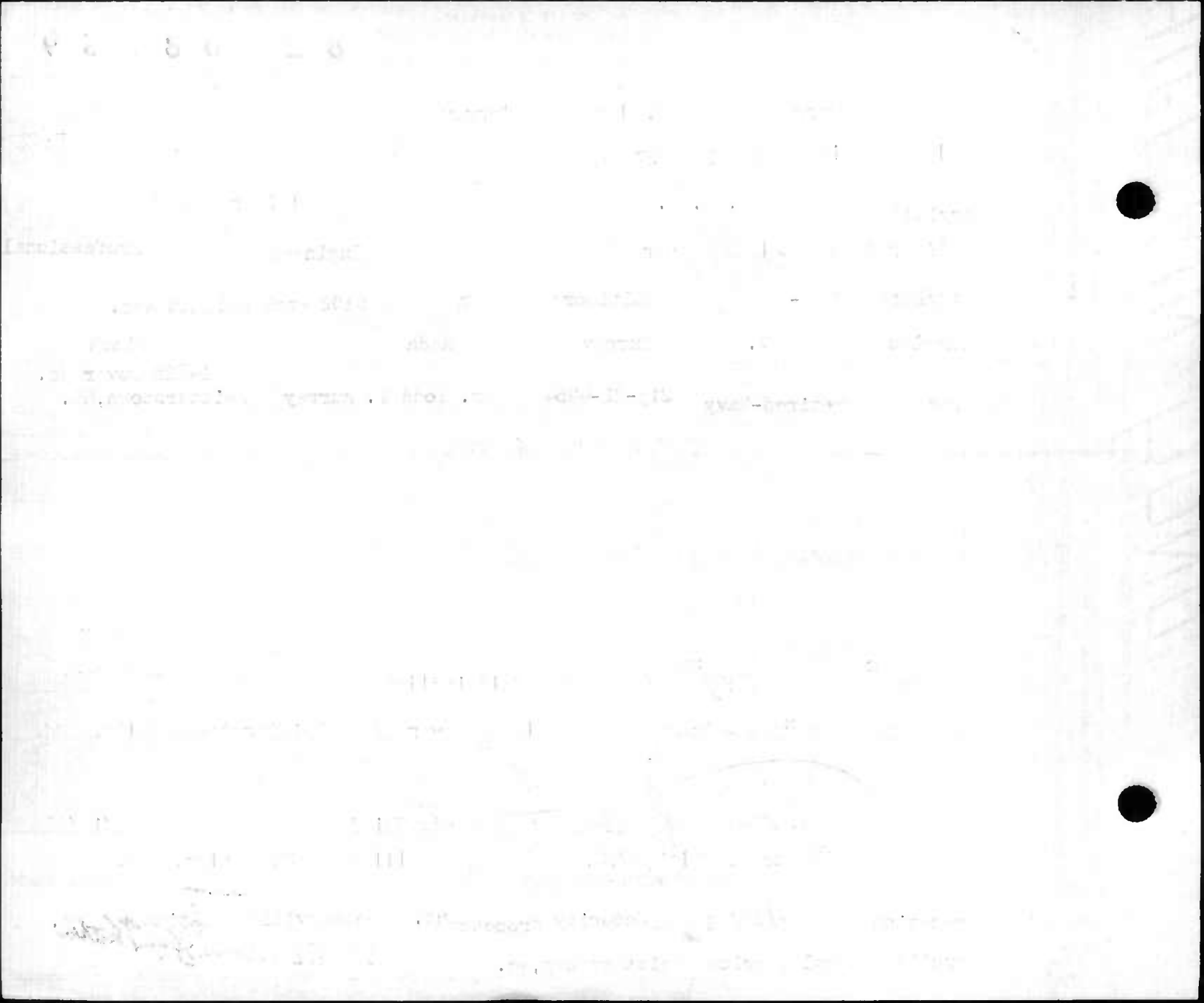


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 2 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 5 2 0 8 7 5 9

|  |         |  |                   |   |                  |
|--|---------|--|-------------------|---|------------------|
| 1. FOR STATE REGISTRAR   |         | 2a. DATE KNOWN OF DEATH  |                   | 2b. HOUR  |                  |
| 1. DECEASED NAME (TYPE OR PRINT)   |         | 2a. DATE KNOWN OF DEATH  |                   | 2b. HOUR  |                  |
| Harry Stanley Murray   |         | 4 9 1982   |                   | M   |                  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH   | 6. AGE (IN YEARS) | IF UNDER 1 YR.  | IF UNDER 24 HRS. |
| Male   | White   | 2 15 27  | 55 YRS.           | MONTHS  | DAYS             |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?   |                   | 8. MARRIED  |                  |
| Maryland   |         | U. S. A.   |                   | NEVER MARRIED   |                  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION   |                   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |                  |
| Reisterstown   |         | 14828 Dover Rd.  |                   | Engineer  |                  |
| 13a. STATE   |         | 13b. CITY OR TOWN  |                   | 13c. STREET ADDRESS   |                  |
| Maryland   |         | Baltimore  |                   | 6102 Park Heights Ave.  |                  |
| 14. FATHER'S NAME  |         | 15. MOTHER'S MAIDEN NAME   |                   | 16. SOCIAL SECURITY NO.   |                  |
| Charles V. Murray  |         | Adda   |                   | 215-22-4964   |                  |
| 17. INFORMANT  |         | ADDRESS  |                   | 18. CAUSE OF DEATH  |                  |
| Mr. Todd E. Murray   |         | 14828 Dover Rd. Reisterstown, Md.  |                   | PART I DEATH WAS CAUSED BY:   |                  |
| 19a. DATE OF OPERATION   |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |                   | 20. AUTOPSY?  |                  |
|  |         |  |                   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |         | 21b. TIME OF INJURY  |                   | 21c. HOW INJURY OCCURRED  |                  |
|  |         | 7:20 P.M. 4 9 1982   |                   | Self inflicted  |                  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK  |         | 21e. PLACE OF INJURY   |                   | 21f. LOCATION   |                  |
|  |         | house  |                   | 14828 Dover Rd. Reisterstown, Balto., Md.                           |                  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from  |         | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |                   | TITLE (SPECIFY)   |                  |
| Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |  |                   | M.D. Deputy Chief   |                  |
| ACTUAL SIGNATURE   |         | DATE SIGNED  |                   | 4/10/82   |                  |
| EXAMINER'S NAME (TYPE OR PRINT)  |         | ADDRESS  |                   | 111 Penn St. Balto., MD.  |                  |
| Thomas D. Smith, M.D.  |         |  |                   |   |                  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |         | 23b. DATE  |                   | 23c. NAME OF CEMETERY OR CREMATORY                                  |                  |
| Cremation  |         | 4/13/82  |                   | Security Process Inc.   |                  |
| 24. FUNERAL DIRECTOR NAME  |         | 24b. DATE REC'D. BY REGISTRAR  |                   | 24c. REGISTRAR SIGNATURE  |                  |
| Marzullo Funeral Service   |         | APR 14 1982  |                   | James J. Smith  |                  |
| ADDRESS  |         | 25a. DATE REC'D. BY REGISTRAR  |                   | 25b. REGISTRAR SIGNATURE  |                  |
| Reisterstown, Md.  |         |  |                   |   |                  |



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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                        |  |   |  |   |  |   |  | REG. NO. 08760   |  |                                       |  |
|--|--|------------------------|--|---|--|---|--|---|--|--|--|---------------------------------------|--|
| 1. FOR STATE REGISTRAR   |  |                        |  |   |  |   |  |   |  |  |  |                                       |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>ROBERT E MURREY, Sr.</b>  |  |                        |  |   |  |   |  |   |  | 2b. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR<br><b>April 17 1982</b>                     |  | 2c. HOUR<br><b>4:15 P.M.</b>          |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>CAU.</b> |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>02 5 15</b>   |  | 6. AGE (IN YEARS) LAST BIRTHDAY MONTHS DAYS<br><b>67 YRS.</b> |  | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR<br><b>April 17 1982</b>   |  | 2d. HOUR<br><b>4:15 P.M.</b>   |  |                                       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Ohio</b>   |  |                        |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.                          |  |                                       |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>   |  |                        |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST. JOSEPH HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Inventory Clerk</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Ret.</b>   |  |                                       |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |                        |  |   |  |   |  |   |  |  |  |                                       |  |
| 13a. STATE<br><b>New York</b>  |  |                        |  | 13b. COUNTY<br><b>Avoca</b>   |  |   |  | 13c. CITY OR TOWN<br><b>Avoca</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>Box 423</b> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Clarence Murrey</b>  |  |                        |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Unknown</b>  |  |   |  |   |  |  |  |                                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br><b>No</b>  |  |                        |  | 16b. SOCIAL SECURITY NO.<br><b>235-05-0804</b>  |  |   |  | 17. INFORMANT ADDRESS<br><b>Mary Ellen Murrey Box 423 Avoca, N.Y.</b>   |  |  |  |                                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>4100 Acute Myocardial Infarction</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost<br>(b) <b>Generalized ASCVD</b><br>(c) <b>5+ yrs</b>   |  |                        |  |   |  |   |  |   |  |  |  |                                       |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I   |  |                        |  |   |  |   |  |   |  |  |  |                                       |  |
| 19a. DATE OF OPERATION   |  |                        |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |   |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |  |                                       |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                        |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>19</b>   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |  |  |                                       |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |                        |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |                                       |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                        |  |   |  |   |  |   |  |  |  |                                       |  |
| ACTUAL SIGNATURE <b>Robert E. Murrey, Sr.</b>  |  |                        |  | TITLE (SPECIFY) <b>Deputy</b> MEDICAL EXAMINER  |  |   |  | DATE SIGNED <b>4/17/82</b>  |  |  |  |                                       |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |  |                        |  | ADDRESS   |  |   |  |   |  |  |  |                                       |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>  |  |                        |  | 23b. DATE<br><b>4/19/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Green Mount</b>      |  |   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>                         |  |                                       |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS<br><b>Leonard J. Ruck, Inc. Baltimore, Maryland</b>  |  |                        |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 19 1982</b>           |  | 25b. REGISTRAR'S SIGNATURE<br><b>James J. Nathan</b>  |  |  |  |                                       |  |

MEDICAL CERTIFICATION

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PMA 3. RETAIN PAGE 1 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17  
(VRA 15 ME (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 8 2 0 8 7 6 1

|   |   |   |   |                                      |   |
|---|---|---|---|--------------------------------------|---|
| 1. FOR STATE REGISTRAR  |   | 2a. DATE KNOWN OF DEATH   |   | 2b. HOUR                             |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |   | 2a. DATE KNOWN OF DEATH   |   | 2b. HOUR                             |   |
| William George Muth, Jr.  |   | 4 4 1982  |   | M                                    |   |
| 3. SEX  | 4. RACE   | 5. DATE OF BIRTH  | 6. AGE (IN YEARS)   | IF UNDER 1 YR.                       | IF UNDER 24 HRS.  |
| Male  | White   | Oct. 29, 1938   | 43 YRS.   | MONTHS                               | DAYS  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?                                | 8. MARRIED  | NEVER MARRIED   | 9. BALTIMORE CITY OR COUNTY OF DEATH |   |
| Maryland  | U.S.A.  | WIDOWED   | DIVORCED  | Baltimore County, MD.                |   |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION    | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                 | 12b. KIND OF BUSINESS OR INDUSTRY                                   |                                      |   |
| Parkton   | Rt. 45 north of Bee Tree Road                               | Carpenter   | Construction  |                                      |   |
| 13a. STATE  | 13b. CITY OR TOWN   | 13c. STREET ADDRESS   | 13d. INSIDE CITY LIMITS?  |                                      |   |
| Pennsylvania  | York  | Shrewsbury  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                      |   |
| 14. FATHER'S NAME   | 15. MOTHER'S MAIDEN NAME                                    | 16. SOCIAL SECURITY NO.   |   |                                      |   |
| William George Muth Sr.   | Eva Dietrich  | 213-36-7777   |   |                                      |   |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES?  | 17b. SOCIAL SECURITY NO.                                    | 17. INFORMANT   |   |                                      |   |
| No  | 213-36-7777   | Marjorie Muth Shrewsbury, PA17361   |   |                                      |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |   |   |   |                                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |
| PART I DEATH WAS CAUSED BY:   |   |   |   |                                      |   |
| IMMEDIATE CAUSE (a) Multiple Injuries   |   |   |   |                                      |   |
| 8150 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.  |   |   |   |                                      |   |
| DUE TO, OR AS A CONSEQUENCE OF  |   |   |   |                                      |   |
| (b)   |   |   |   |                                      |   |
| DUE TO, OR AS A CONSEQUENCE OF  |   |   |   |                                      |   |
| (c)   |   |   |   |                                      |   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |   |   |   |                                      |   |
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |   |   |                                      | 20. AUTOPSY?  |
|   |   |   |   |                                      | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  | 21b. TIME OF INJURY   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |   |                                      |   |
|   | 10:23 P.M. 4 4 1982   | driver in auto/fixed object impact  |   |                                      |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION   |   |                                      |   |
|   | Road  | Rt 45 north of Bee Tree Rd., Balto. Co., Md.                                  |   |                                      |   |
| 22a. I certify that I took charge of the remains described above, held on   |   |   |   |                                      |   |
| Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion  |   |   |   |                                      |   |
| death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |   |   |   |                                      |   |
| ACTUAL SIGNATURE  |   | TITLE (SPECIFY)   |   | DATE SIGNED                          |   |
| Virginia L. Dolan   |   | M.D. Assistant  |   | 4-5-82                               |   |
| EXAMINER'S NAME   |   | ADDRESS   |   |                                      |   |
| (TYPE OR PRINT)   |   | Virginia L. Dolan, M.D.   |   | 111 Penn Street                      |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   | 23b. DATE   | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION                        |   |
| Burial  | Apr. 8, '82   | Dulaney Valley Mem. Gar.  |   | Balto. Co., MD                       |   |
| 24. FUNERAL DIRECTOR  | 25a. DATE REC'D. BY REGISTRAR                               |   | 25b. REGISTRAR'S SIGNATURE  |                                      |   |
| William E. Johnson  | APR 7 1982  |   | James J. Nathan   |                                      |   |
| NAME  |   | ADDRESS   |   |                                      |   |
| William E. Johnson  |   | 8521 Loch Raven Blvd.   |   |                                      |   |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                          |  |   |  |   |  |   |  | 8 2 0 8 7 6 2   |  |                                   |  |
|--|--|--------------------------|--|---|--|---|--|---|--|---|--|-----------------------------------|--|
| FOR STATE REGISTRAR  |  |                          |  |   |  |   |  |   |  | REG. NO.  |  |                                   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>ERNEST L. MYERS   |  |                          |  |   |  |   |  |   |  | 2b. DATE KNOWN OF DEATH<br>ESTIMATED<br>MONTH DAY YEAR<br>4-23-82                   |  | 2c. HOUR<br>M<br>2:54P            |  |
| 3. SEX<br>male   |  | 4. RACE<br>white         |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Nov. 13, 1932   |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br>49 YRS.   |  | IF UNDER 1 YR.<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>4-23-82                               |  | 2d. HOUR<br>M                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  |                          |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  |   |  | 8. MARRIED<br><input checked="" type="checkbox"/> NEVER MARRIED<br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                        |  |                                   |  |
| 10. CITY OR TOWN OF DEATH<br>Towson  |  |                          |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Joseph's Hospital |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |                          |  |   |  |   |  |   |  |   |  |                                   |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Baltimore |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>6625D Collingsdale Rd.   |  |   |  |                                   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Ernest Myers   |  |                          |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Edna Kimmit                                    |  |   |  |   |  |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No  |  |                          |  | 16b. SOCIAL SECURITY NO.<br>216-28-1795   |  | 17. INFORMANT<br>Georgeann Bain Myers   |  |   |  | ADDRESS<br>Same   |  |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>4292 IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH              |  |                          |  |   |  |   |  |   |  |   |  |                                   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                          |  |   |  |   |  |   |  |   |  |                                   |  |
| 19a. DATE OF OPERATION   |  |                          |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                                   |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                          |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |  |   |  |   |  |                                   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |                          |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |                                   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                          |  |   |  |   |  |   |  |   |  |                                   |  |
| ACTUAL SIGNATURE<br>Margarita A. Korell, M.D.  |  |                          |  |   |  | TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER  |  |   |  | DATE SIGNED<br>4-24-82  |  |                                   |  |
| EXAMINER'S NAME (TYPE OR PRINT) ADDRESS<br>Margarita A. Korell, M.D., 111 Penn Street  |  |                          |  |   |  |   |  |   |  |   |  |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>4/29/82     |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Eastview  |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore City, Maryland  |  |   |  |                                   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212  |  |                          |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 3 1982   |  | 25b. REGISTRAR'S SIGNATURE  |  |   |  |                                   |  |

[Faint, mostly illegible text covering the main body of the page, possibly a letter or report.]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 8 7 6 3

REG. NO.

|  |  |  |   |   |  |  |   |  |   |  |
|--|--|--|---|---|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Mitchell</i> <b>Mitchell</b> <i>B.</i> <b>Myers</b><br><i>Myers</i>   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>April 12, 1982</b>                     |   | 2b. HOUR<br>M  |  |   |  |   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>white</b>  |   | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Feb. 11, 1907</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS<br><b>75</b>                                     |   | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS HOURS MIN   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Essex</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Riverview Nursing Home</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Carpenter</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Construction</b>   |   |  |
| 13a. STATE<br><b>Maryland</b>  |  |  | 13b. COUNTY<br><b>Baltimore</b>   |   | 13c. CITY OR TOWN<br><b>Essex</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>2326 Martin Drive 21221</b> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Thomas Myers</b>   |  |  |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Edith Shipley</b>   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>213 03 7376</b> |   | 17. INFORMANT ADDRESS<br><b>Dolores M. Booth 21220<br/>120 Covered Wagon Road</b>  |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic Coronary Vascular Disease</b><br><b>4140</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |   |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Spondylitis, Arthritis, Parkinson's, Senile dementia</b>   |  |  |   |   |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                              |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                       |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, EARM, ETC.)        |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |   |  |  |   |  |   |  |
| 22b. SIGNATURE<br><i>Richard J. [Signature]</i> MD   |  |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |   | 22c. DATE SIGNED<br><b>4-12-82</b>   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |   |   | 22e. ADDRESS   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(CHECK ONE)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>4-14-82</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holly Hill Mem. Gardens</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore County, Maryland</b>                 |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>Brozdinski Funeral Home PA 1407 Old Eastern Ave.</b>  |  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 14 1982</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>James Van Nuthen</i>   |  |   |  |

